PROJET INTEGRE DE VIH/SIDA AU CONGO (PROVIC)

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FROM THE AMERICAN PEOPLE

Cover Photo: Felix Masi
Listening for baby at Kenya Reference Hospital, Lubumbashi, DR Congo, November 2013

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ACRONYMS AND ABBREVIATIONS

3TC	lamivudine, epivir
AB	abstinence/be faithful
AIDS	Acquired Immune Deficiency Syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral medication
ASF/PSI	*Association de Sante Familiale*/Population Services International
AVEC	*Association Voluntaire epargne et Credit*
AZT	zidovudine
C2C	Child-to-Child
CBO	community-based organization
C-Change	Communication for Change
CDC	US Centers for Disease Control and Prevention
CEMAKI	*Centre Maman Kinzembo*
COP	Country Operational Plan
CNTS	*Centre National de Transfusion Sanguine*
CPCC	*Comite De Pilotage Des Communautés*
CS	*Centre de Santé*
CSR	*Centre de Santé de Reference*
DBS	dried blood spot
DOD	US Department of Defense
DRC	Democratic Republic of Congo
EFV	efavirenz
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	early infant diagnosis
EMMP	Environmental Mitigation and Monitoring Plan
FANTA	Food and Nutrition Technical Assistance
FP	family planning
FY	Fiscal Year
GARP	Global AIDS Response Progress
GBV	gender-based violence
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAART	highly active antiretroviral therapy
HTC	HIV testing and counseling
HGR	*Hôpital Général de Référence*
HIV	human immunodeficiency virus
IR	Intermediate Result
LCD	Local Capacity Development
LIFT	Livelihood and Food Security Technical Assistance
LPV/r	lopinavir and ritonavir
M&E	monitoring and evaluation

MNCH	maternal, newborn, and child health
MOH	Ministry of Health
MSM	men who have sex with men
NACS	Nutrition Assessment, Counseling, and Support
NGO	nongovernmental organization
NVP	nevirapine
OVC	orphans and vulnerable children
PATH	Program for Appropriate Technology in Health
PBF	performance-based financing
PEPFAR	US President's Emergency Plan for AIDS Relief
PITC	provider-initiated HIV testing and counseling
PLWHA	people living with HIV/AIDS
PMEP	Performance Monitoring and Evaluation Plan
PMTCT	prevention of mother-to-child transmission of HIV
PNLS	*Programme National de Lutte Contre le VIH/SIDA*
PNMLS	*Programme National Multisectoriel de Lutte Contre le VIH/SIDA*
PNSR	*Programme National de Santé de la Reproduction*
PNTS	National Blood Transfusion Program
ProVIC	*Projet Intégré de VIH/SIDA au Congo*
PSSP	*Progrès Santé Sans Prix*
QA/QI	quality assurance/quality improvement
RDQA	routine data quality assurance
SBCC	social and behavior change communication
SCMS	Supply Chain Management System
sdNVP	single-dose nevirapine
SGBV	sexual and gender-based violence
STI	sexually transmitted infection
SW	sex worker
TB	tuberculosis
TB/HIV	tuberculosis and HIV co-infection
TDF	tenofovir
TWG	Technical Working Group
UNTA	Ambulatory Treatment Nutritional Unit
UNTI	Intensive Treatment Nutritional Unit
URC	University Research Co., LLC
USAID	US Agency for International Development
VCT	voluntary HIV counseling and testing
VSLA	village savings and loan association
WHO	World Health Organization

EXECUTIVE SUMMARY

Year 4 of ProVIC *(Projet Intégré de VIH/SIDA au Congo)* in the Democratic Republic of Congo (DRC) was characterized by continued success with the project meeting the majority of its targets. PATH and the consortium partner's achievements under ProVIC included: more than 55,000 pregnant women learning their HIV status and receiving appropriate follow-up services, nearly 60,000 people from key populations reached with prevention messages, and more than 15,000 GBV service encounters at health facilities.

In many ways, ProVIC's Year 4 was also defined by the Strategic Pivot, which was announced by the US Agency for International Development (USAID)/US President's Emergency Plan for AIDS Relief (PEPFAR) in March 2013. PATH led the ProVIC consortium to quickly and effectively "pivot" to this change in technical strategy, transforming ProVIC from a largely community-based HIV program built on the Champion Community platform into a health facility-based program built on the prevention of mother-to-child transmission of HIV (PMTCT) platform, including provision of antiretroviral therapy (ART) for adults and children. To execute the Strategic Pivot, ProVIC expanded to 103 health facilities, which now offer a comprehensive package of HIV/AIDS care and support services while maintaining increasingly focused community-level linkages and ProVIC's well-established work with key populations.

ProVIC continued to foster PEPFAR's goal of country ownership by increasing alignment with the DRC government's Health Zone Strategy. ProVIC's activities are coordinated, supervised, and integrated into Health Zone management systems, including clinic- and community-based activities. Health Zone Chief Medical Officers are routinely integrated into *Comite De Pilotage Des Communautés* (Champion Community Steering Committees) and are present at the signing of all contracts with health facility and community actors from their Health Zones to strengthen ownership of these activities by the Health Zones themselves.

ProVIC's ability to successfully meet the Strategic Pivot needs was supported by the introduction of innovative quality initiatives such as the Mentor Mother approach and "Improvement Collaboratives." Both initiatives yielded positive results with reductions in loss to follow-up of pregnant women and their children and increased male participation. The Mentor Mother approach is being scaled up across USAID's priority provinces of Katanga, Kinshasa, and Orientale for Year 5.

ProVIC's community-based prevention work continued to be based on its Champion Community model, which is widely praised by government counterparts for its inclusion of a significant community role to address HIV/AIDS. At the DRC government's national AIDS conference held in July 2013, the Champion Community model was repeatedly cited as a model to be replicated, including by the Minister of Health himself. Nevertheless, in alignment with the Strategic Pivot, ProVIC ended its support to 26 of its total 49 champion communities as they were not directly connected to ProVIC-supported health facilities (although they were linked to Global Fund to Fight AIDS, Tuberculosis and Malaria sites). The remaining 23 champion communities,

supported through grants with local nongovernmental organizations, are now primarily focused on prevention activities and awareness-raising linked to PMTCT and treatment services.

ProVIC's granting system grew exponentially during the year and by the end of Fiscal Year (FY) 2013, ProVIC was managing 124 separate local granting agreements. The Strategic Pivot equally affected ProVIC's geographic presence in PEPFAR non-priority provinces; operations in Sud Kivu were discontinued at the end of FY2013 as were ProVIC's community-based activities in Bas-Congo. Clinical services continue in Bas-Congo through the end of the project.

Analysis of ProVIC's results for this fiscal year is complicated in that the year was divided almost equally between two very different strategies. The first six months, Q1 and Q2, of the project retained ProVIC's community-based design, while the Q3-Q4 post-Pivot period shifted interventions significantly toward health facilities. As such, much of the data and analysis highlighted in this report focus more on the post-Pivot period, but ultimately the annual data reflect this entire transitional year.

Prevention of mother-to-child transmission of HIV

With the Pivot's focus on the PMTCT platform, there is now a focus on the PMTCT cascade of services. The narrative of this cascade is summarized here and analyzed in detail in Sub-IR 1.3.

- In FY2013, 52,838 pregnant women were counseled and tested (95% of target), 45,672 pregnant women received HIV counseling during antenatal care (ANC) and 7,166 at labor and delivery. Thus, 84% of pregnant women who received PMTCT services were reached in ANC and 16% of ProVIC clients presented first at labor and delivery. Of the total 52,838 pregnant women counseled, 52,585 women (99.6%) were tested and learned their HIV status.
- Of the 52,585 tested, 1,381 were HIV positive. Of these women, 1,105 were newly diagnosed as HIV positive by ProVIC, and 276 women presented with known HIV-positive status. These results reflect a general seropositivity of 2.1% among pregnant women who accepted HIV testing at ProVIC sites, including 3.3% in Katanga, 2.5% in Orientale, and 2.3% in Bas-Congo.
- Of the 1,381 HIV-positive pregnant women, 1,025 (75%) were assessed for ART through either clinical staging or CD4 testing. A total of 1,170 HIV-positive women (85%) were initiated on either antiretroviral medications (ARVs) for PMTCT or ART for life (736, or 63%, were placed on maternal zidovudine and 434, or 37%, were started on ART for life).
- When adding previous cohorts of pregnant women receiving PMTCT-based ART and with the new cohort, which adds PMTCT-based ART as well as the new comprehensive program of lifelong ART, ProVIC now supports 2,857 individuals on ART, including many family members.
- A total of 502 HIV-positive pregnant women delivered at ProVIC-supported health facilities, and 500 infants (100%) born to HIV-positive mothers received ARV prophylaxis to prevent HIV transmission during the recommended breastfeeding period.
- Early infant diagnosis of 669 HIV-exposed infants was conducted during the reporting period (44% of the annual target of 42%), and 121 infants were initiated on cotrimoxazole prophylaxis.

HIV testing and counseling

The results of HIV testing and counseling (HTC) activities reflect the periods before and after the Strategic Pivot. A principle recommendation of the new strategy is to increase focus on provider-initiated HIV testing and counseling (PITC) in health facilities, with a reduced focus on community testing, which resulted in the closure of fixed community HTC sites and a reduction in mobile testing. In the first six months, 64% of beneficiaries were tested through community-level HTC while 36% were tested via PITC and PMTCT in clinical settings. In alignment with the technical shift, in Q3 and Q4, 89% of beneficiaries were tested in health facilities while 11% were tested via community approaches; specifically, mobile HTC focused on key populations (men who have sex with men, sex workers, and truck drivers).

Care and support and treatment

The Strategic Pivot shifted increasing numbers of services from community interventions to health facilities, with specific focus on cotrimoxazole prophylaxis, tuberculosis (TB) screening, and nutrition screening and counseling. Education for orphans and vulnerable children (OVC) remains a community-based intervention. Key results included:

- A total of 20,812 people living with HIV/AIDS and OVC received at least one care service (114% of target).
- Of these, 10,581 received at least one clinical service (122% of target).
- Of the 10,581 who received one clinical service, 7,953 received cotrimoxazole (91% of target).
- Of the 10,581 who received one clinical service, 8,375 were screened for TB (116% of target), including 83 who started TB treatment.
- In all, 5,987 of eligible clients received nutrition services (88% of target).
- A total of 10,126 OVC received at least one care service, including psychosocial and education.
- A total of 2,427 OVC received educational support (81% of target).

Health systems strengthening

ProVIC continued to expand its alignment with the Health Zone Strategy by extending contractual accords and support to 34 Health Zones in which the project operates. ProVIC continued to support national-level initiatives and was a key player in the development of the National AIDS Strategic Plan for 2014-2017, participating in many technical working groups. ProVIC also provided leadership and support to the *Programme National de Lutte Contre le VIH/SIDA* in the development of tools and guidelines for PITC, which are presently nonexistent, presenting a barrier to effective PITC implementation and reporting of results.

In summary, ProVIC's FY2013 program was highly successful, with targets being met and exceeded in nearly every case. This report details those interventions.

SECTION I: PROGRESS BY TECHNICAL COMPONENT

Intermediate Result 1: HIV testing and counseling and prevention services improved in target areas

Sub-IR 1.1: Communities' ability to develop and implement prevention strategies strengthened

Overview

Rolled out in March 2013, the new US Agency for International Development (USAID)/US President's Emergency Plan for AIDS Relief (PEPFAR) prevention of mother-to-child transmission of HIV (PMTCT) Strategic Pivot has shaped ProVIC's approach to improving HIV testing and counseling (HTC) and prevention services in target areas of the Democratic Republic of Congo (DRC). In response to the Strategic Pivot, ProVIC reoriented its activities under Intermediate Result 1 to focus on testing within the PMTCT cascade of services. As this shift occurred in mid-year, after six months of implementation pre-Pivot, community mobilization initiatives implemented using the Champion Community approach played a central role in targeting key populations and raising general population awareness about HIV/AIDS prevention and support during the reporting period.

ProVIC targeted key populations and vulnerable groups including both adults and youth through peer education and social and behavior change communication (SBCC). ProVIC held communications strategy trainings to build the capacity of Champion Community volunteers to raise awareness around PMTCT and HIV prevention services and behaviors in their communities. The project also provided interpersonal communication sessions focused on behavior change throughout the five provinces to provide information directly to key populations on available health services and HIV prevention. Promotion of healthy behaviors such as abstinence/be faithful (AB), delayed sexual debut, and use of condoms contributed to the ability of communities to effectively prevent transmission of HIV. Specific examples of the success of the Champion Community model in Fiscal Year (FY) 2013 include the following:

- More than 284,215 people were reached with HIV-related prevention messages through interpersonal communication, peer education, and door-to-door awareness campaigns.
- A total of 58,791 members of key populations were reached with HIV-related prevention messages through interpersonal communication and peer education through existing key population networks in the five target provinces.
- In all, 40,430 youth were reached with AB messages through youth groups and youth-focused events.
- A total of 334 people, including 175 individuals from key populations, 90 peer educators, and 69 community health workers were trained in communication skills for behavior change, specifically in relation to HIV prevention and family planning.

- A total of 735 members of *Comite De Pilotage Des Communautés* (CPCCs—Champion Community Steering Committees) were trained in the Champion Community approach.

Activities and achievements

Activity 1: Reinforce and expand access to prevention services for key populations and other vulnerable groups.

To improve planning and coordination of interventions targeted at key populations and vulnerable groups, ProVIC collaborated with Health Zones, CPCCs, *relais communautaires*, peer educators, youth, students, and representatives from religious and health groups to conduct HIV risk and vulnerability mapping. The mapping was done in four Health Zones and seven champion communities in Sud Kivu, three Health Zones and four champion communities in Province Orientale, three Health Zones and four champion communities in Bas-Congo, and all Health Zones and champion communities in Katanga. Across the regions, the mapping exercise was conducted hand in hand with CPCCs, and has enabled champion communities to identify groups most vulnerable to HIV, identify high-risk practices and behaviors within their communities, identify Champion Community priority actions and targets for the fight against HIV, and identify areas and venues frequented by key populations. Mapping was not conducted in Kinshasa due to shifting priorities following the Strategic Pivot, but ProVIC was able to use data gathered through a similar Joint United Nations Programme on HIV/AIDS-funded mapping exercise for use by champion communities in the province.

In Year 4, ProVIC used the Champion Community model intensively to increase access to prevention services by key populations and other vulnerable groups. ProVIC closely collaborated with the *Programme National de Lutte Contre le VIH/SIDA* (PNLS) and *Programme National Multisectoriel de Lutte Contre le VIH/SIDA* (PNMLS), Health Zones, and grantees to build the capacity of peer educators, community agents, and health service providers in SBCC; conduct outreach activities; revise a peer educator training manual; conduct HIV risk and vulnerability mapping; and maintain peer educator and community agent engagement.

ProVIC revised the PNLS peer education training module in Year 4 to add a chapter on peer education for men who have sex with men (MSM); this rounds out the module to include peer education training on prevention and treatment activities targeted toward all key populations. The revised training module received positive feedback from the PNLS, which has adopted the MSM module for use in their core training curriculum. The PNLS also recommended that ProVIC organize a three-day workshop with experts and partners to obtain their input on the module. At the time of this writing, ProVIC was exploring ways to finance the requested workshop with co-funding from the PNLS.

ProVIC continued to use peer education to reach out to key populations and vulnerable groups such as MSM, sex workers (SWs), miners, fishermen, and truck drivers to increase their knowledge of prevention services and available care and support in ProVIC-supported health facilities. MSM and SWs in DRC are often marginalized and difficult to reach, which has presented an ongoing programmatic challenge. To address this, in Year 4 ProVIC trained an additional 175 MSM and SW peer educators to reach out to peer MSM and SWs with prevention messages. ProVIC also facilitated the creation of eight support networks of peer groups for MSM

and SWs. Peer educators used skills learned in SBCC trainings to organize HIV prevention activities within these networks on topics such as sensitization of female sexual partners of MSM and other lesbian, gay, bisexual, and transgender individuals; promotion of and proper use of condoms and water-based lubricants; voluntary HIV counseling and testing (VCT) referral; recognition of sexually transmitted infection (STI) symptoms and referrals of STI patients to health structures; proper care of anal infections; and placement in self-help groups for psychosocial support of seropositive MSM and SWs. Finally, peer educators from the Kinshasa MSM network have worked to identify facilities like *Centre de Santé* (CS) St. Hilaire, where they can safely receive appropriate treatment without stigmatization. However, clinics like CS St. Hilaire frequently lack the resources to meet the needs of all MSM and SW clients, reinforcing the importance of identifying additional health facilities that welcome MSM and SWs. Peer educators are working with their communities to advocate for health facilities to treat these patients.

To ensure that SWs and MSM have greater access to testing services, during Year 4 ProVIC emphasized the need for SW and MSM peer educators to accompany clients throughout the full cycle of the mobile HTC process. This involvement of peer educators throughout the cycle of HTC has better enabled educators to encourage their peers to get tested and to support clients who test positive. In parallel, ProVIC continued to reach out to all key populations and vulnerable groups through community mobilization activities led by community agents and peer educators using a wide range of methods adapted to each community and target population, including discussions in small groups, door-to-door outreach, distribution of brochures, referral to HIV and STI testing centers, and distribution of condoms (see Figure 1 and Table 1).

Figure 1. Breakdown of key populations reached per province.

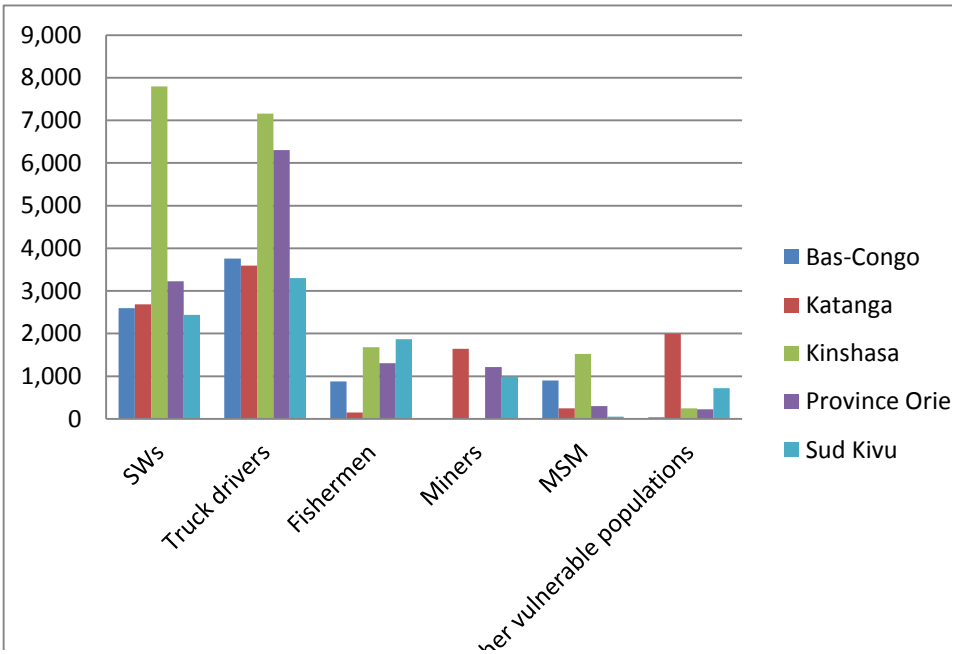


Table 1. Key populations reached with prevention messages.

Key population	Bas-Congo	Katanga	Kinshasa	Province Orientale	Sud Kivu
SWs	2,595	2,687	7,798	3,222	2,435
Truck drivers	3,760	3,590	7,161	6,299	3,302
Fishermen	880	145	1,679	1,302	1,867
Miners	0	1,643	0	1,211	986
MSM	899	243	1,519	301	51
Other vulnerable populations	34	1,993	246	222	721

To increase visibility, awareness, and motivation of trained peer educators and community workers, ProVIC assembled more than 600 promotional materials kits in Year 4, including bags, t-shirts, caps, and pens; the kits were distributed to peer educators and community workers. ProVIC adapted some of the kits, and accompanying messages, to the specific needs of the MSM population.

Activity 2: Mobilize communities around health facilities with high prevalence to increase demand, service utilization, and involvement of male partners

In the second half of Year 4, ProVIC shifted efforts to target communities around health facilities with high prevalence in all five provinces. The following are highlighted activities conducted to that end in the target communities.

To engage communities around health facilities to increase demand, service utilization, and involvement of male partners, ProVIC worked with champion communities to develop action plans to address behavior change promotion and implement numerous outreach activities such as direct peer-to-peer outreach, social mobilization, and advocacy targeting vulnerable demographic groups (students, youth, married women, pregnant women, teenage mothers, etc.). Communications activities integrated messaging tailored to target groups around HIV, family planning, and sexual and gender-based violence (SGBV), with a strong focus on PMTCT. This messaging stressed the importance of involving male partners of pregnant women to ensure effective and lasting impacts of PMTCT services.

In April 2013, ProVIC held a four-day workshop in Kinshasa in partnership with Communication for Change (C-Change), a USAID-funded behavior change communication program, to build the capacity of 52 community agents to deliver key PMTCT-integrated messages to pregnant women, their partners, and key populations. During the workshop, community agents developed communications materials that included demonstration kits, visual aids, and flashcards with key discussion points, to aid in the delivery of messages to their communities to ultimately increase the use of services. PMTCT-specific communications tools included messages encouraging women to get tested for HIV and to know their HIV status, and to visit health facilities for antenatal consultation; promoting involvement of male partners; and advising HIV-positive pregnant women to give birth in a maternity ward with PMTCT-appropriate equipment and services. Messaging for HIV-positive pregnant women also emphasized the key elements of PMTCT: community outreach, testing, family planning, prevention of transmission from mother to child, and care and support. This workshop resulted in the creation of four new demonstration toolkits and flashcards to be used by peer educators,

community agents, and health workers both at the community level and in health centers. These new demonstration toolkits and flashcards will be tested in December 2013 before they are rolled out and used in intervention sites. The PNLS has been involved throughout the development process of these new tools, which will be tested in December 2013 and validated by the PNLS before they are rolled out and used in intervention sites.

Also in Year 4, ProVIC encouraged health service providers and community agents in target areas to collaborate closely to facilitate participation of male partners in PMTCT at health facilities and in the community. Health service providers and community agents worked together to set common target numbers of prevention message recipients and to develop a plan to achieve these targets. Community agents facilitated and spoke at group discussion sessions held in health facilities to educate pregnant women and their partners on PMTCT and to encourage them to use health services available at the facilities. Community agents also attended facility visits and group sessions to ensure that information being communicated to patients was accurate and in line with established standards. Written invitations were sent by health facilities in collaboration with community agents to male partners of pregnant women, inviting them to attend the full PMTCT cycle in support of their pregnant partner. In addition, health structure schedules were modified to accommodate partners of pregnant women and encourage them to receive HTC. A total of four health facilities in Kinshasa (Binza, Kisangani, Kikimi, and Libondi) have adapted their schedules to offer access to testing services 24/7 for partners of pregnant women. To improve health facility-to-community linkages, ProVIC worked with health centers to establish systems to carefully track pregnant women who missed follow-up check-ins so that community agents could reach out to these women and their families.

Activity 3: Improve youth access to HIV prevention services through peer education in and around health facilities with high HIV rates

Youth, especially those with multiple sex partners, face an elevated risk of HIV. At the same time, they have limited access to information regarding HIV prevention, placing them at increased risk of infection. In Year 4, per the Strategic Pivot, ProVIC worked with youth groups around health facilities with high HIV prevalence to equip youth with knowledge and skills to help them better assess HIV/AIDS risk factors. ProVIC implemented a methodology whereby peer educators and community agents worked with youth groups to develop action plans to minimize HIV/AIDS risk factors through their own information dissemination, outreach, and awareness-raising activities. To this end, ProVIC's peer educators organized bi-monthly meetings in 15 champion communities with youth groups of more than 40 participants each. During these meetings, peer educators educated participants on behaviors that reduce or eliminate the risk of contracting HIV, such as AB, avoidance of contaminated objects such as sharps, monogamy, delayed first sexual intercourse, use of condoms and other contraceptives, avoidance of harmful substances such as alcohol, tobacco, and drugs, and other practices reinforcing sexual health. The peer educators also distributed male and female condoms during these meetings. In addition, the meetings provided a forum for youth to ask questions freely of their peers and to share concerns about topics like general sexual health, SGBV, and other HIV/AIDS concerns.

In addition to the peer educator meetings, community volunteers used group and one-on-one discussions, door-to-door visits, and demonstration toolkits to reach out to 119,987 youth with

HIV prevention messages and information about HIV prevention, counseling, and testing services available at health centers in their area.

In Year 4, ProVIC reached a total of 40,430 youth aged 15-24 years with AB messages (49% of the 82,346 people reached with AB messages). In all, 53% of the 40,430 youth reached with AB messages were female.

Activity 4: Develop an exit plan for previously developed champion communities without a PMTCT site in the local Health Zone

In response to the Strategic Pivot, in Year 4 ProVIC discontinued support to 27 champion communities that lacked a ProVIC-supported health facility offering PMTCT services in their local Health Zone, and began transitioning these champion communities to Health Zone support. ProVIC developed a comprehensive exit plan and is guiding the champion communities through the plan's implementation to ensure sustainability of the Champion Community structure and continuity of services and support to people living with HIV/AIDS (PLWHA) and orphans and vulnerable children (OVC) following ProVIC's withdrawal.

The exit plan was developed through a collaborative process involving implementing partners of each Champion Community. The plan includes step-by-step instructions with timelines, and maps out the transition in four phases. During the first phase, ProVIC identifies the Champion Community to be transitioned from ProVIC support and shares this decision with the Champion Community's CPCC. ProVIC then evaluates Champion Community activities to determine which initiatives were successful, the community's priority activities, and what improvements to Champion Community activities might be necessary. ProVIC meets with community stakeholders and ProVIC partners, including the Health Zone, to discuss the results of the evaluations and highlight weaknesses, lessons learned, and best practices. In the final phase, ProVIC meets with *Equipe Cadre de Zone de Santé* to encourage them to fully integrate the Champion Community into the formal local health system.

ProVIC also provided support to champion communities to draft their internal procedures manuals in order for them to gain the legal status of community-based organization (CBO). Ten champion communities in Sud Kivu have completed the exit plan process, and five have obtained CBO status. All 11 champion communities in Bas-Congo have obtained CBO status. Kinshasa's six champion communities are in the process of becoming CBOs. ProVIC has also started preparing health facilities not affected by the Pivot in advance of their transition from direct ProVIC support to Health Zone support upon the project's closure in 2014. Community agents in 11 champion communities in Katanga and five champion communities in Kisangani were integrated into their Health Zone development committees in the last quarter of Year 4.

Sub-IR 1.2: Community- and facility-based HTC services enhanced

Overview

HTC is the entry point for HIV-positive individuals into the continuum of care, including PMTCT, care, and support services; thus, HTC remains at the core of ProVIC's strategy. During Year 4, ProVIC focused on three categories of HTC activities: PMTCT and provider-initiated

HIV testing and counseling (PITC), and VCT/mobile testing in Katanga and Kinshasa. Community-based testing at fixed HTC sites was phased out of ProVIC in the second half of the year, per Strategic Pivot guidance. Further, in accordance with the new guidance, ProVIC placed increased emphasis on PITC, providing training to health care providers, promoting access to services through PITC entry points, and validating normative PITC guidance documents.

ProVIC shifted mobile VCT by eliminating the targeting of the general population to exclusively concentrating on key populations and continued to work with local partner nongovernmental organizations (NGOs) World Production in Katanga and *Projet Santé Sans Prix* (PSSP) in Kinshasa. Also in accordance with the Pivot, ProVIC stopped all testing in Sud Kivu and worked with the PNLS and health facilities to develop a plan to continue providing HTC within health facilities via support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). At this time, it is anticipated that the PNLS will supervise the testing and treatment program with financial support from donors, including the Global Fund.

Year 4 was also marked by an increased emphasis on promoting the continuum of care through a strengthened referral system. ProVIC transitioned to a system of referring clients to clinics as close to the testing site as possible, and worked to actively build relationships with health facilities through formal and informal agreements in an effort to reduce loss to follow-up. Whereas ProVIC would previously identify and provide mobile HTC in the hottest of "hot spots," the project now exclusively offers mobile HTC in Health Zones where ProVIC also supports the entire continuum of care, including ProVIC-supported health facilities.

Activities and achievements

Activity 1: Provide high-quality HTC services to priority beneficiaries

During Year 4, ProVIC provided high-quality testing services to 84,902 clients in clinical settings, versus 73,419 in community-based settings. In total, ProVIC provided HTC services to 158,321 clients in Katanga, Bas-Congo, Province Orientale, and Kinshasa, including 35,565 members of key populations.

During the first half of FY2013, ProVIC's HTC activities focused on community-based settings targeting the general population, reaching more clients in community-based than clinical settings. With the Strategic Pivot, during the second half of the implementation period, ProVIC focused on increasing testing in clinical settings by scaling up facility-based testing via increased health facilities and PITC, reducing mobile HTC (while improving referrals), and stopping all other community-based HTC (see Figure 2 and Table 2 below).

ProVIC has limited support of mobile HTC to working with World Production and PSSP, partners which focus efforts on key populations only. At the same time, ProVIC has worked closely with Health Zones to further involve health facilities in the referral system, and increased testing in clinical settings, ramping up PMTCT and PITC through all entry points. As a result of this shift in focus to clinical settings, ProVIC tested 89% of clients in clinical settings in the second half of FY2013, a 53% increase from the first half of the project year. The figure and table clearly demonstrates the shift from a community-based testing focus in the pre-Pivot period to a focus on clinical testing in the post-Pivot period.

Figure 2. Percentage of ProVIC clients tested in community versus clinical settings.

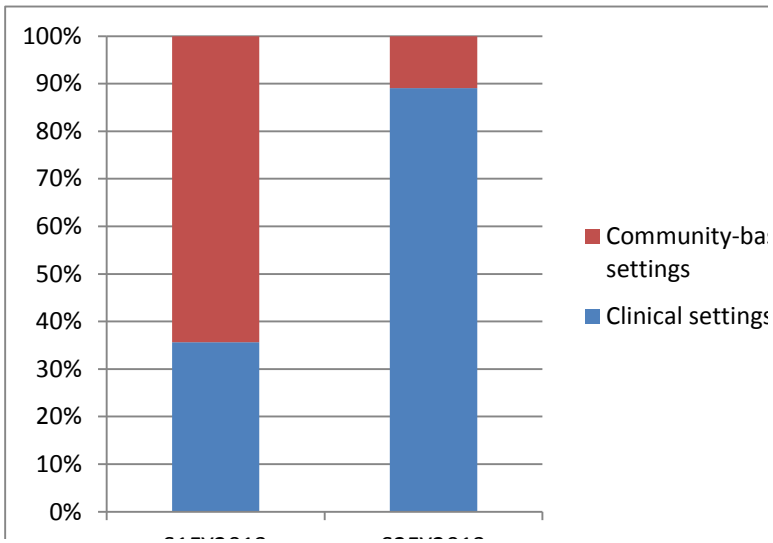


Table 2. Clients tested in clinical versus community settings, FY2013.

Setting	Q1 and Q2	Q3 and Q4	Total
Clinical	37,415	47,487	84,902
Community-based	67,604	5,815	73,419

As part of the nine integrated HTC trainings implemented during the year, ProVIC built the capacity of 659 health care providers and community agents to provide high-quality HTC services. These trainings incorporated prevention and care and support modules according to national PNLS standards, with emphasis on PMTCT, PITC, laboratory testing, biomedical waste management, and continuum of care. A total of 393 health care providers received PITC training. ProVIC now offers PITC services in all 103 supported health facilities. As part of PITC trainings, health care providers received guidance on offering PITC services through alternative entry points, such as external consultations, tuberculosis and HIV co-infection (TB/HIV) and STI testing centers, nutrition centers, and hospitalized and in-patients. ProVIC has instructed health facilities to offer PITC through all entry points; by expanding the reach of PITC through a variety of entry points, ProVIC is able to reach more clients. This is evidenced by the fact that the number of clients who received PITC services has increased significantly, from 34.5% in Year 3 to 53.6% in Year 4.

In FY2013, ProVIC exceeded the target number of total HTC clients—149,179—by 6%, or 9,142 clients. Table 3 illustrates results and seropositivity rates disaggregated by province.

Table 3. Number of clients tested and seropositivity rates by province, FY2013.

HIV status	Bas-Congo	Katanga	Kinshasa	Province Orientale	Sud Kivu	Total
Positive	1,368	3,178	2,778	414	314	8,052
Negative	23,218	42,507	62,494	8,146	13,904	150,269
Total	24,586	45,685	65,272	8,560	14,218	158,321
Serpositivity rate	6%	7%	4.2%	5%	2%	5%

In addition to individual service providers, ProVIC built the capacity of NGO partners World Production and PSSP to provide high-quality HTC services and target key populations by providing medical supplies and equipment, as well as technical support and guidance. With this support, World Production and PSSP have focused on targeting only key populations rather than the general population with HTC services, and they have used peer educators and community leaders of specific key populations as resources to effectively engage with these groups. As ProVIC is the only significant HIV/AIDS program in DRC offering HTC services to these populations, the project has been the source of data and technical strategy in the development of the DRC government's National AIDS Strategic Plan for 2014-2017.

In order to ensure the continuum of care through mobile VCT, ProVIC works with World Production and PSSP in coordination with these peer educators and community leaders to identify specific key population groups and determine sustainable referral and counter-referral systems. World Production and PSSP organize mobile testing only once these elements have been established to guarantee an effective continuum of care. The following table shows seropositivity rates disaggregated by key population and province.

Table 4. Key population seropositivity rates.

Key population	HIV status	Bas-Congo	Katanga	Kinshasa	Kisangani	Sud Kivu	Total
SWs	Positive	59	160	531	17	87	854
	Negative	805	1,611	7,547	193	1,736	11,892
	Total	864	1,771	8,078	210	1,823	12,746
Seropositivity rate		**6.8%**	**9.0%**	**6.6%**	**8.1%**	**4.8%**	**6.7%**
Fishermen	Positive	23	37	171	11	11	253
	Negative	277	87	1,635	39	664	2,702
	Total	300	124	1,806	50	675	2,955
Seropositivity rate		**7.7%**	**29.8%**	**9.5%**	**22.0%**	**1.6%**	**8.6%**
Miners	Positive	1	133	0	14	33	181
	Negative	7	1,249	0	107	1,311	2,674
	Total	8	1,382	0	121	1,344	2,855
Seropositivity rate		**12.5%**	**9.6%**	**0.0%**	**11.6%**	**2.5%**	**6.3%**
MSM	Positive	14	1	344	3	1	363
	Negative	128	76	2,017	18	19	2,258
	Total	142	77	2,361	21	20	2,621
Seropositivity rate		**9.9%**	**1.3%**	**14.6%**	**14.3%**	**5.0%**	**13.8%**
Injection drug users	Positive	0	0	3	0	0	3
	Negative	0	0	6	3	0	9
	Total	0	0	9	3	0	12
Seropositivity rate		**0.0%**	**0.0%**	**33.3%**	**0.0%**	**0.0%**	**25.0%**
Truck drivers	Positive	75	187	558	18	34	872
	Negative	1,206	2,800	7,890	179	1,429	13,504
	Total	1,281	2,987	8,448	197	1,463	14,376
Seropositivity rate		**5.9%**	**6.3%**	**6.6%**	**9.1%**	**2.3%**	**6.1%**

Throughout the implementation period, ProVIC emphasized continuum of care for all clients of HTC services. Emphasizing the importance of improved referral systems, which are historically very weak in DRC, ProVIC hosted trainings for partner organizations on the importance of referrals and counter-referrals. As a result, 462 participating health care providers, including

nurses, doctors, pharmacists, laboratory technicians, and Health Zone chief doctors and nurses better understand the importance of referral/counter-referral systems and referral data collection procedures, and are in turn ensuring the continuum of care and improving information management. Based on data collected in areas where the project works, PITC has proven to result in lower rates of loss to follow-up than VCT; therefore, ProVIC is scaling up PITC activities and providing VCT only for key populations. To promote continuum of care for mobile VCT clients, ProVIC added service providers from health care centers to mobile HTC teams, who provide Health Zone supervision of the referral process, and trained World Production and PSSP health care providers in the referral system and tools to track the continuum of care. ProVIC will closely monitor the effectiveness of mobile HTC referrals throughout FY2014. Further discussion on ProVIC's efforts to strengthen referral systems can be found under Intermediate Result 3.

Since the PEPFAR Strategic Pivot, ProVIC has tested 52,783 clients through health facilities and established partnerships with 59 new health facilities, bringing the total number of ProVIC-supported health facilities to 103. Increased testing through health facilities also contributed to enhanced continuum of care, as the PMTCT program has built-in structures to encourage clients to continue receiving services through the entire PMTCT cascade. Through the PMTCT program, if a woman tests positive for HIV, she is first referred for diagnosis and prescribed the most appropriate treatment, and then referred to a self-help group, a Mother Mentor, or other support structure within her Champion Community, where she receives psychosocial support and access to income-generating activities. The combination of medical follow-up treatment and community support has helped to ensure a continuum of care for PMTCT clients. The rate of loss to follow-up for PMTCT clients was 2% in Year 4. ProVIC also linked non-PMTCT clients to community and peer support in addition to referrals for treatment to reduce loss to follow-up.

In order to guarantee that all ProVIC-supported health facilities were equipped to conduct testing and counseling, ProVIC provided all 103 facilities with sufficient supplies of testing equipment, including PIMA™ Analysers, Determine®, Uni-Gold™ Recombigen®, and Double Check™ HIV test kits, and Determine® syphilis tests. ProVIC also ensured adequate supplies of laboratory equipment for dried blood spot (DBS) testing sample collection, serological analyses, and biomedical waste management, although the DBS collection papers themselves were stocked out. The project successfully supplied health facilities with equipment and medical supplies throughout the year, ensuring that facilities did not experience shortages.

Activity 2: Support the National Blood Transfusion Program in ensuring good transfusion safety in ProVIC partner sites

ProVIC hosted a training in transfusion safety in Q3, as part of the integrated PMTCT/HIV prevention and treatment training, which incorporated prevention outreach, medical and psychosocial care and support, and mitigation of the impact of HIV at the individual, family, and community levels. In all, 659 doctors, nurses, laboratory technicians, and community agents participated in the transfusion safety training. ProVIC also collaborated with the National Blood Transfusion Program (PNTS), with the support of the US Centers for Disease Control and Prevention (CDC) and the Global Fund, to ensure that all health facilities are equipped with transfusion safety equipment. ProVIC plans to establish a sustainable framework in the first quarter of Year 5 for collaboration between health facilities, Health Zone central offices, and

PNTS, to ensure blood transfusion safety through trained staff, information-sharing, and equipment provision.

Activity 3: Support the PNLS in updating the PITC trainer's guide and tools for data collection

In Year 4 Q3, ProVIC worked with the PNLS to update the PITC trainer's guide and data collection tools, which includes a training manual, a job aid, and a set of norms and standards for PITC. The trainer's guide and tools have since been validated, and the reproduction of these tools for distribution is planned for the first quarter of Year 5. One tool, a pocket guide to PITC for health care providers, provides recommendations and key points in communicating HIV prevention and testing messaging with clients, an outline of the testing and counseling processes, and guidance on obtaining consent, maintaining a sterile environment, and maintaining confidentiality. ProVIC also produced a comprehensive PITC trainer's guide, which provides facilitators with informational content, participant activities, and messaging guidance for different populations.

To streamline the data collection processes for health facility staff, ProVIC is currently supporting the PNLS in the development of their data collection tool, which will include mechanisms for health facilities to collect data from both PITC and mobile and community VCT. The PNLS tool will aim to minimize paperwork and facilitate accurate data collection through a format that is easy for health care providers to use.

Activity 4: Support injection safety and biomedical waste management in all health intervention sites

Throughout Year 4, ProVIC was committed to minimizing the spread of disease and other health risks, taking scrupulous measures to promote injection safety and management of biomedical waste. In addition to training health workers and community agents in injection safety, the project provided appropriate medical supplies and trainings to all health facilities to support safe injections. Supplies included disposable needles, hazardous waste disposal containers, sterile gloves, alcohol, and tourniquets.

In support of proper biomedical waste management, ProVIC provided targeted biomedical waste management training to 53 service providers, 30 in Katanga and 23 in Kisangani. In addition, ProVIC provided biomedical waste management training as one segment of the integrated HIV training focused on PMTCT that was given in five provinces in FY2013 in line with the Strategic Pivot. As a result, 659 service providers (social workers, doctors, nurses, laboratory technicians, and community workers) were trained in Bas-Congo, Katanga, Province Orientale, and Kinshasa in biomedical waste management. This training included modules on biosafety, post-exposure accident management, waste incineration and disposal procedures, and maintenance of sterile conditions during testing. Over the course of FY2013, 712 medical professionals received training in biomedical waste management.

In addition, ProVIC directly invested in waste management systems in several of its sponsored sites in FY2013. Three incinerators were installed in Bas-Congo, at *Hôpital Général de Référence* in Boma (HGR Boma), *Centre de Santé de Reference* in Vulumba (CSR Vulumba), and *Centre de Santé de Reference* in Mbami (CSR Mbambi). In Sud Kivu, a destruction site for

managing biomedical waste was renovated, and a fence built around it to prevent people, specifically neighboring children, from wandering into the site and risking exposure. In Kinshasa and Province Orientale, ProVIC continued to supply adequate quantities of required commodities to ensure proper handling, sorting, collection, transportation, and disposal of biomedical waste. In Katanga, ProVIC provided these supplies, as well as other necessary equipment. ProVIC continues to provide all health facilities and local partner organizations with supplies to manage biomedical waste, such as protective gloves, bleach, sharps disposal bins, biomedical waste receptacles, trash bags, rubber boots, and cleaning supplies.

Sub-IR 1.3: PMTCT services improved

Overview

PMTCT activities began in 2010 at 16 health facilities in four provinces. In Year 3, ProVIC expanded its coverage of PMTCT interventions gradually, to 44 health facilities in the five target provinces. In Year 4, following the guidance of the Strategic Pivot, increased emphasis was placed on the importance of PMTCT services and the continuum of care for PLWHA as the centerpiece for an integrated HIV program. Key considerations included:

- Reinforcing health facilities by providing support to Health Zones around data validation, supply chain management, and strengthening of referral systems between community- and facility-based activities.
- Quality improvement of PMTCT services provided to pregnant women and their families through a complete package of HIV continuum of care services and use of PMTCT as the entry point for comprehensive services: planning for antiretroviral therapy (ART) for HIV-positive women and their families, including start-up of Option B+ activities in select PMTCT Hubs in Katanga; TB/HIV care and support; cotrimoxazole prophylaxis; psychosocial support (through self-help groups); services to help HIV-positive women improve treatment adherence and live positively with their families; and OVC care and support.
- Progressive extension of PMTCT activity coverage in project-supported Health Zones, in order to reach at least 85% coverage in each supported Health Zone.
- Possible extension of PMTCT activities to new, higher HIV prevalence Health Zones, in order to reach a greater number of HIV-positive pregnant women and reach the greatest number of families and individuals with a complete package of PMTCT services.

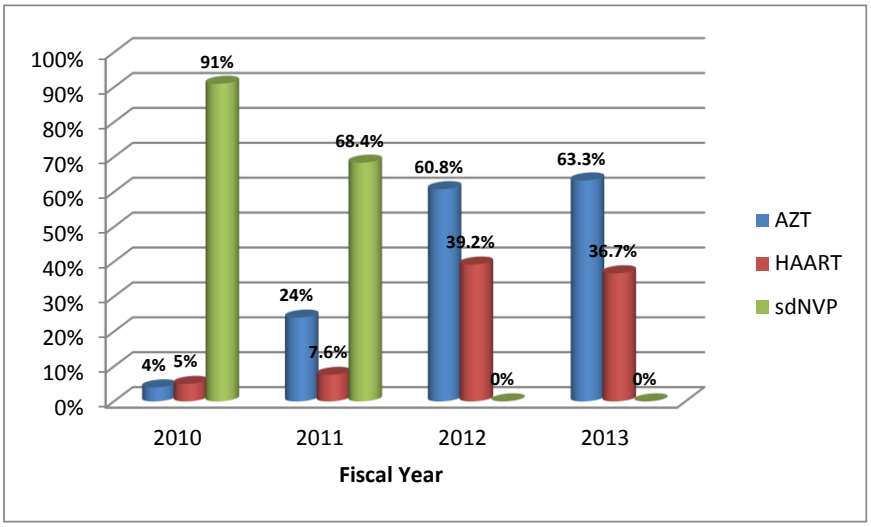
Thus, in FY2013, ProVIC increased the number of health facilities from 44 to 103 in four provinces (Sud Kivu was closed). The 59 additional sites began activities in Q4. Table 5 below provides a summary of health facility coverage for FY2010 through FY2013.

Table 5. Health facility coverage, FY2010–FY2013.

Fiscal Year	Number of provinces	Number of Health Zones	Number of health facilities
2010	4	13	16
2011	4	13	16
2012	5	25	44
2013	5	28	103
2014	4	28	103

This extension of coverage was accompanied by expansion of the existing package of services to take into consideration the four pillars of comprehensive PMTCT being implemented in DRC. At the same time, the DRC protocol for HIV-positive women has evolved from single-dose nevirapine to Option A, and, more recently, to the introduction of Option B+, in alignment with the World Health Organization's (WHO) new recommendations (see Figure 3). For its part, ProVIC started the pilot of Option B+ in the last quarter of 2013, in six sites in Lubumbashi, Katanga Province.

Figure 3. Trends in antiretroviral regimens in ProVIC-supported health facilities, FY2010–FY2013.



AZT: zidovudine; **HAART:** highly active antiretroviral therapy; **sdNVP:** single-dose nevirapine.

Throughout Year 4, ProVIC continued to play a key role at the national level, advising the PNLS and the Ministry of Health (MOH) on the most efficient and cost-effective way to adapt the WHO guidelines for PMTCT and infant feeding into DRC's national protocols, and to update the national integrated HIV training materials according to the new standards.

To facilitate the implementation of activities in the sites and to obtain the expected results, ProVIC collaborated actively with the MOH through the PNLS, *Programme National de Santé de la Reproduction* (PNSR), Department of Maternal and Child Health, and provincial health teams to ensure the adherence of project-supported PMTCT activities with national standards and to strengthen governmental leadership of HIV activities. ProVIC also worked closely with

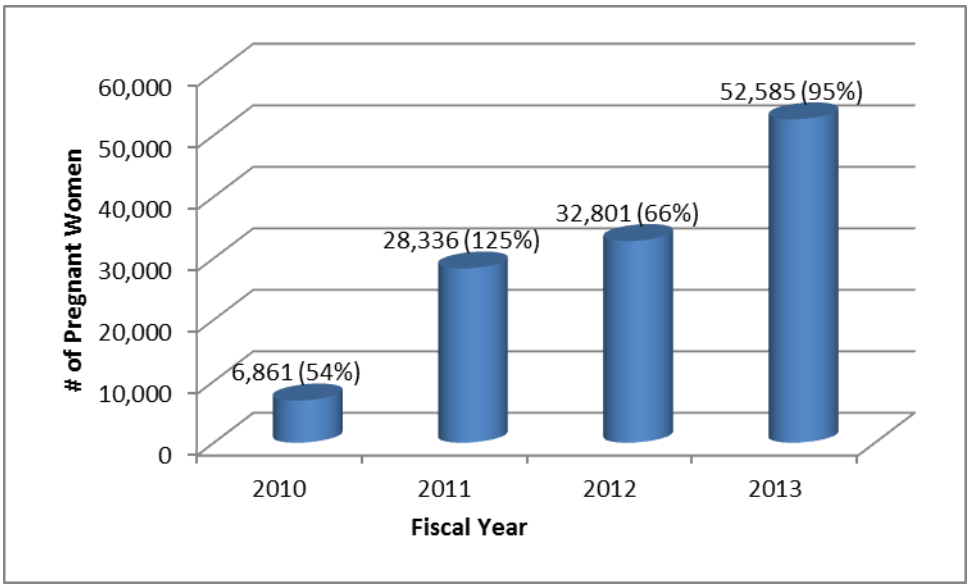
other PEPFAR implementing partners and the Global Fund to harmonize interventions on the ground.

During 2013, ProVIC continued to provide technical and financial support to the DRC government in capacity-building of providers through provision of integrated HIV package training, commodities, and data collection tools, and reinforcement of ongoing supervision.

Support from the Elizabeth Glaser Pediatric AIDS Foundation Headquarters team to improve the monitoring of activities, September 2013.

In 2013, ProVIC piloted three innovative approaches to improve the quality of services: the Mentor Mother and collaborative quality assurance/quality improvement (QA/QI) approaches and the performance-based financing (PBF) model focused on PMTCT activities. All of these support mechanisms have helped to improve upon expected ProVIC results for the number of pregnant women tested during antenatal care (ANC) and labor and delivery (Figure 4).

Figure 4. Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results).



With this increase in the number of pregnant women tested for HIV during ANC services, it has become even more important to have better linkages between PMTCT and ANC services (delivery, postnatal consultation, etc.) and between the activities carried out in health facilities and those carried out in the community, an area ProVIC continues to emphasize.

Over the course of FY2013, 52,585 pregnant women were counseled, 44,697 at ANC and 7,888 at labor and delivery. Thus, 15% of ProVIC clients presented first at labor and delivery. All (100%) were tested and learned their HIV status. The PMTCT cascade of services realized during the year is presented in Table 6.

Table 6. PMTCT cascade; trends observed in Year 4.

PMTCT cascade indicator	Bas-Congo	Katanga	Kinshasa	Province Orientale	Sud Kivu	Total
Pregnant women counseled at ANC	7,108	13,398	16,790	4,576	3,800	45,672
Women counseled at delivery	357	2,833	2,764	527	685	7,166
Total women counseled	7,465	16,231	19,554	5,103	4,485	52,838
Pregnant women tested	7,465	16,231	19,454	5,103	4,332	52,585
P1.1.D Number of pregnant women with known HIV status (including women who were tested for HIV and received their results) + known positives at entry	7,465	16,231	19,454	5,103	4,332	52,585
Total HIV-positive women screened at a facility (ANC and delivery)	170	534	229	128	44	1,105
Seropositivity	2.3	3.3	1.2	2.5	1.0	2.1
HIV-positive pregnant women at entry	45	95	99	26	11	276
Number of HIV-positive pregnant women identified in the reporting period (including known positives at entry)	215	629	328	154	55	1,381
Total women evaluated (with CD4 assay at ANC and at clinic)	171	430	291	98	54	1,044
Total women on zidovudine prophylaxis	150	305	155	80	36	726
Total women on ART	45	205	136	31	17	434
P1.2.D Number of known HIV-positive pregnant women who received ARVs to reduce risk of vertical transmission (reported)	172	453	244	85	65	1,019
Number of exposed children on ARVs for PMTCT	47	167	173	36	51	474
C4.1.D Number of infants who received an HIV test within 12 months of birth during the reporting period	16	58	28	7	12	121
C4.2.D Number of infants born to HIV-positive women started on cotrimoxazole prophylaxis within two months of birth	332	397	3,147	660	146	4,682
Number of male partners tested for HIV	17	38	27	12	4	98
Number of male partners who tested positive for HIV	5.1	9.6	0.9	1.8	2.7	2.1
Seropositivity	6	21	86	10	0	123
Other family members tested for HIV	1	5	1	0	0	7

ARV: antiretroviral medication.

A total of 1,381 pregnant women who received PMTCT services during the reporting period were HIV positive; of these women, 1,105 were newly diagnosed by ProVIC and 276 presented with known HIV-positive status. These results reflect a general seropositivity of 2.1% among pregnant women who accepted HIV testing at ProVIC sites, representing 3.3% in Katanga, 2.5% in Orientale, and 2.3% in Bas-Congo.

Of the 1,381 HIV-positive pregnant women mentioned above, 1,044 (76%) were assessed for ART through either clinical staging or CD4 testing. A total of 1,160 HIV-positive women (84%) were initiated on either antiretroviral medications (ARVs) for PMTCT or ART for life (with 726 women, or 63%, placed on maternal zidovudine and 434 women, or 37%, started on ART for life).

Early infant diagnosis of 474 HIV-exposed infants was also conducted during the reporting period, and 121 infants were initiated on cotrimoxazole prophylaxis.

A total of 4,682 male partners were counseled and tested for HIV and received their results during this period. Of these men, 98 were HIV positive, reflecting a seropositivity rate of 2.1% among male partners. Eleven men received CD4 count testing and nine who were eligible were placed on ART. A total of 79 male partners were placed on cotrimoxazole prophylaxis.

In all, 123 other family members were tested for HIV; seven tested HIV positive and ineligible for treatment, but were started on cotrimoxazole.

Activities and achievements

Activity 1: Complete the package of comprehensive PMTCT services at ProVIC sites

ProVIC continued to improve progressively throughout FY2013, providing HIV-positive pregnant women and their families with high-quality services, including prevention, care, support, and treatment, in its 103 functional health facilities.

ProVIC made a commitment to complete the PMTCT package in Spokes and Hubs in accordance with PEPFAR orientations and in alignment with national standards and policies. This integrated package takes into account: (1) community activities carried out through sensitization messages provided by community workers to support male partner involvement, and to encourage pregnant women to seek early ANC (in the first quarter of their pregnancy), complete all four ANC visits, and follow up on their children's under-five care; and (2) health facility activities to reduce mother-to-child transmission of HIV, which consisted of providing:

- PITC to pregnant women and their male partners, including initiating HIV-positive people on ART, in accordance with the current national protocol on either prophylaxis or treatment.
- Maternal and child health services to prevent factors that increase the risk of vertical transmission, such as syphilis screening and treatment, SGBV and tuberculosis (TB) screening, referral/counter-referral for positive cases, malaria prevention, and nutrition screening.
- Support groups for HIV-positive women and their families to reinforce retention and adherence (Mentor Mother and self-help groups at health facilities or community-level self-

help groups), and follow-up of mother-child pairs, including early infant diagnosis, cotrimoxazole within two months of birth, and ART for infected children.

At the Hubs, this package is completed through CD4 count and provision of care for the major side effects of ART.

During this period, ProVIC continued to focus on increasing the promotion and uptake of pediatric counseling and testing and improving follow-up of mother-infant pairs. ProVIC also worked to ensure effective referrals of infected infants to treatment and the initiation of HIV-exposed infants on cotrimoxazole. The referral system for placing HIV-infected children on ART was strengthened through continued phone calls to mothers and through reinforcing management at sites where referred women received follow-up, to better ensure the success of the referral.

Activity 2: Increase the number of sites offering PMTCT services within ProVIC-supported Health Zones

As part of the guidance of the Strategic Pivot, ProVIC was advised to increase coverage (and sites) in Health Zones already covered by ProVIC as well as to add strategic new Health Zones in Katanga and Province Orientale. In Q3 of FY2013, ProVIC adapted PEPFAR's strategic recommendations and increased PMTCT coverage within existing Health Zones by partnering with new health facilities with reported higher HIV prevalence as well as higher facility attendance by pregnant women. ProVIC then implemented the appropriate package of PMTCT services as required at Spokes and the additional package in existing Hubs prior to extending project support to 52 new sites identified in current intervention Health Zones located in Kinshasa, Orientale, and Katanga Provinces.

A needs assessment was conducted in Q3 to identify 52 new sites in Health Zones and a large-scale, integrated training of 659 health care providers was conducted with the PNLS in new sites in PEPFAR's strategic provinces of Katanga, Orientale, and Kinshasa. These new sites subsequently initiated activities in Q4.

To reach targets in Health Zones with markedly low attendance, ProVIC worked with Health Zone management teams to introduce a "*strategie avancee*". Similar to the main Hub and Spoke model, this strategy seeks larger geographic coverage and involves a smaller Hub site working with increasingly secondary, lower-volume sites to better reach pregnant women and ensure that those women have access to the continuum of care according to national standards.

Activity 3: Expand the package of PMTCT services into new Health Zones

Subsequent to the extension within existing Health Zones, ProVIC developed plans to extend into four new high-prevalence, high-volume Health Zones, two in Orientale (Mangobo and Bunia) and two in Katanga (Kamina and Bukama). The peer-to-peer approach running between Spokes and Hubs, particularly for CD4 count analysis and care for major ART-related side effects, was implemented in those Health Zones. The training of providers and provision of commodities at these sites occurred in July-August 2013.

Activity 4: Pilot innovative PMTCT approaches

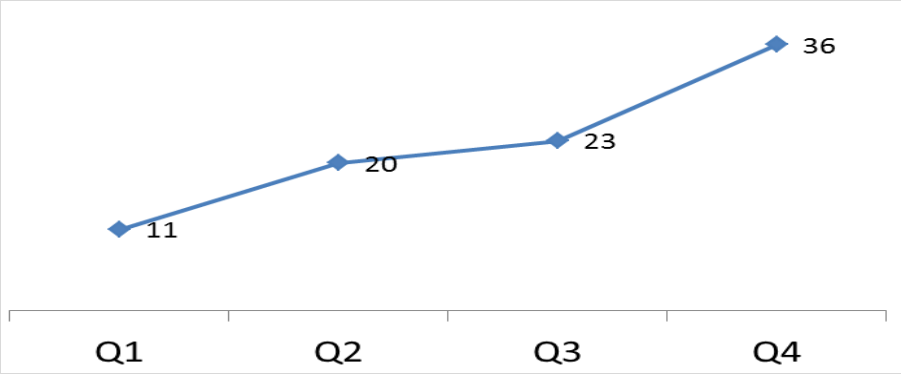
Mentor Mother approach: To improve adherence and retention of HIV-positive pregnant women in PMTCT services, ProVIC targeted six health facilities in Kinshasa, Katanga, and Orientale to pilot the Mentor Mother approach. The pilot's design was informed by the Elizabeth Glaser Pediatric AIDS Foundation's (EGPAF) experiences implementing the approach in Kenya.

In collaboration with the PNLS and PNSR and with support from EGPAF/DRC, ProVIC developed national guidelines for piloting the Mentor Mother approach in DRC. As part of this effort, one module with 17 sessions and eight data collection tools were developed. A total of 24 HIV-positive Mentor Mothers and 30 health care providers involved in PMTCT activities were trained on the approach. Mentor Mother activities were then launched in March 2013.

During the reporting period, the trained Mentor Mothers started coaching HIV-positive women through support group meetings conducted at health facilities under supervision of providers and Health Zone senior staff. They also conducted home visits to track women lost to follow-up. The integration of PMTCT, care, and support activities reinforces the capacity of Mentor Mothers regarding the positive prevention package. Those activities ran successfully in Kinshasa and Province Orientale, where Mentor Mothers were encouraged in their work by their partners. Mentor Mothers helped many newly diagnosed HIV-positive women to accept their status more easily and to come to health facilities with their partners.

During the two quarters of Mentor Mother activities, ProVIC noticed a significant increase in indicators reflecting the retention of HIV-positive women at sites driving the approach. One such case was at the Kisangani maternity in Kinshasa, where the number of HIV-positive pregnant women returning to give birth at the site had increased since the introduction of the approach (as shown in Figure 5 below). Through this approach, Mentor Mothers were also able to reach out to other HIV-positive pregnant women who had previously been lost to follow-up. This resulted in additional women returning for delivery at the facility where they had been officially recruited through the Mentor Mother process. Also, ProVIC has continued to strengthen the collaboration and linkages between health facilities and self-help groups to improve adherence and retention of HIV-positive women.

Figure 5. Trend of deliveries for HIV-positive pregnant women at the Kisangani maternity, FY2013.



After six months of piloting this approach, an evaluation was conducted by a team of staff from the PNLS, Department of Maternal and Child Health, EGPAF/DRC, and ProVIC to measure the effectiveness of the approach and the results and decide on its extension. The table below summarizes the main findings and recommendations of the evaluation.

Table 7. Findings and recommendations from evaluation of the Mentor Mother approach.

Evaluation point	Sub-domain	Score	Comments
Programming	Availability of resources	82%	ProVIC has made available all the material necessary to facilitate the implementation of activities, including the development of local mentors for mothers.
Results achieved through the services	Support for HIV-positive pregnant women Empowerment of women Active search for those lost to follow-up	75%	100% of women tested positive during the period were followed by Mentor Mothers; more than 80% joined self-help groups onsite (retention rate >80%); and 54% shared their status with their male partner.
Overall assessment of the evaluation: 78%. Piloting the Mentor Mother approach has reached the minimum acceptable standard.			

Mentor Mother activities are currently taking place at six sites; Katanga Province has experienced difficulties in the implementation of the approach, where three out of the four Mentor Mothers have become pregnant, and thus not able to effectively offer the services expected of them.

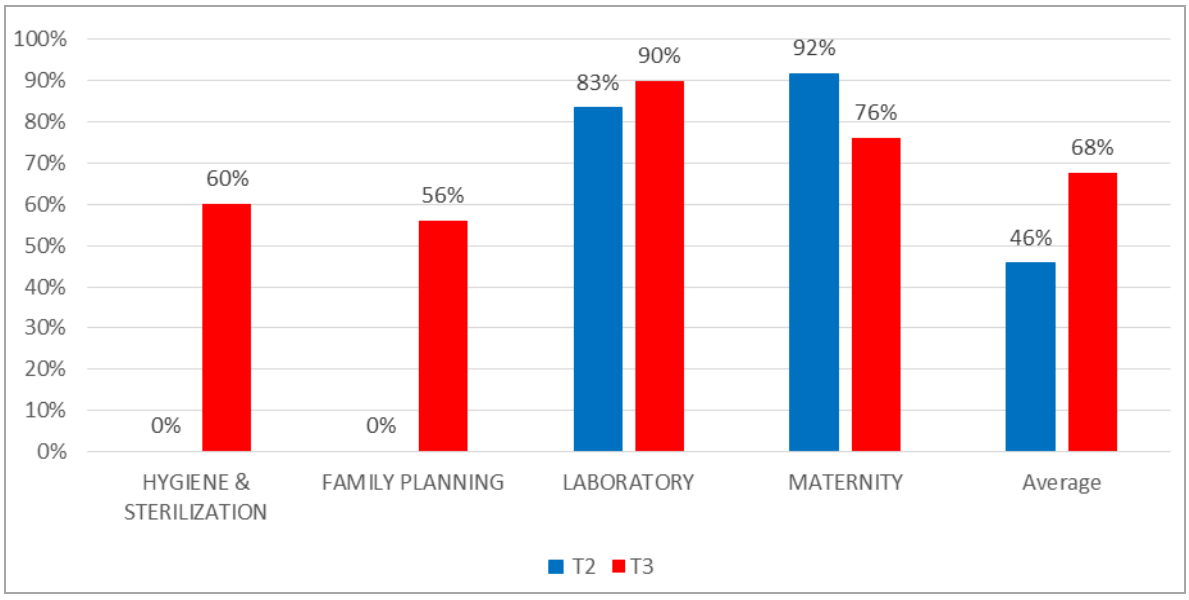
PBF at Kikimi Hospital Center: In collaboration with both the DRC government (the MOH Secretary General) and USAID, ProVIC launched its first PBF for PMTCT pilot at Kikimi Hospital Center in Kinshasa at the end of Q2. In contrast to ProVIC's traditional way of providing financing (fixed monthly budgets or direct support based on identified need), the PBF mechanism budget is determined (up to a pre-set maximum) based on the results achieved.

During Q3 and Q4, Kikimi Hospital Center focused on quality improvement of PMTCT services as the principle objective of their PBF contract, with the intention of using funds to start work on creating a new space for education messages and a counseling corner. There will also be rooms for ANC visits including involvement of Mentor Mothers. These changes will improve the client flow of pregnant woman during ANC visits because they will receive all necessary services at the same location and will avoid traveling long distances, which, more often than not, results in loss to follow-up. ProVIC coached the Kikimi team on the development of a business plan and preparation for administrative and community verification required after three months of work.

At the end of the reporting period, two quarterly evaluations were led by the MOH with USAID support. Results indicated there is good understanding of the PBF implementation process, qualitative and quantitative verification processes are conducted, and the tool index is used on the distribution of subsidies. It should be noted, however, that based on ProVIC's experience, establishment of a PBF is highly time intensive, as multiple actors are involved, and coordination of a complex PBF program is a longer process than organizing traditional means of financing health facilities. In isolation (ProVIC has only a single PBF), this was feasible, but when considering future scale-up of this approach, USAID should recognize that the start-up of multiple PBFs simultaneously would be a heavy burden on any granting/administrative system.

As shown in Figure 6, four of the five areas evaluated showed improvement from Q2 to Q3 (reflected in the graph as T2 and T3). The decrease for maternity is due to the absence of the trained service provider, and staff available during that provider's absence not being briefed.

Figure 6. Comparison of findings from two evaluations on quality improvement.



From this experience, ProVIC staff can be an important resource in case an extension of the PBF approach is considered. This experimental model of PBF-based PMTCT at Kikimi Hospital Center is highly appreciated by the MOH PBF Technical Unit, which recommended that the World Bank and WHO draw upon ProVIC's lessons learned and apply them to their PBF approaches.

Space built at Kikimi Hospital Center with PBF funds to house services such as ANC education sessions and Mentor Mother activities.

Good working environment for Mentor Mothers.

Rollout of QA/QI "Improvement Collaboratives" in ProVIC-supported maternities: With technical support from University Research Co., LLC (URC), as a subcontractor to PATH, ProVIC selected 14 maternities (six in Kinshasa, six in Katanga, and two in Orientale) as QA/QI activity pilot sites. QA/QI activities began in four of the maternities in Kinshasa in January 2013. ProVIC organized the orientation session for government partners in each province, and trained 69 multidisciplinary coaches to ensure ongoing coaching visits to targeted maternities. Three months into implementation at the Kinshasa maternities, ProVIC facilitated a learning session with all of these actors as an opportunity to exchange ideas and improve service quality and site performance. The first package of changes implemented by providers in Kinshasa has been emulated for the extension of the approach to the Kisangani and Lubumbashi sites.

This approach has proven very beneficial in that it increases the ability of providers to analyze their strengths and weaknesses and implement effective ideas for improving their performance. As shown in Figure 7, from the Binza maternity, several steps first diagramed as "clouds" (see photo on the left) for not conforming to the standards required for PMTCT services have improved (see photo on the right). The steps in this approach to improve service quality are easy to follow and "doable" within the context of facility work, thus allowing providers to quickly implement changes. The results after three months of activities in all the structures were significant. Indicators of collaboration (all four structures in fair competition) saw a rise. Figure 8 shows how QA/QI activities in four sites in Kinshasa contributed to male involvement in the province. This graph shows that most male partners were identified in sites implementing the QA/QI collaborative approach. Indeed, providers at these sites have established mechanisms to seize every opportunity to identify male partners.

Figure 7. Evolution of the initial process diagram at the Binza maternity.

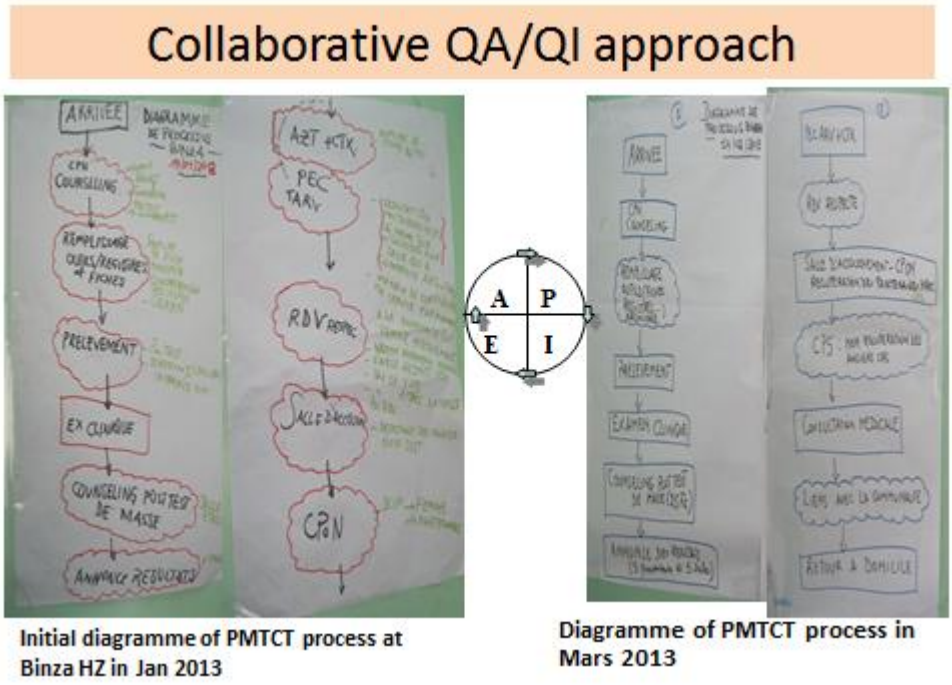
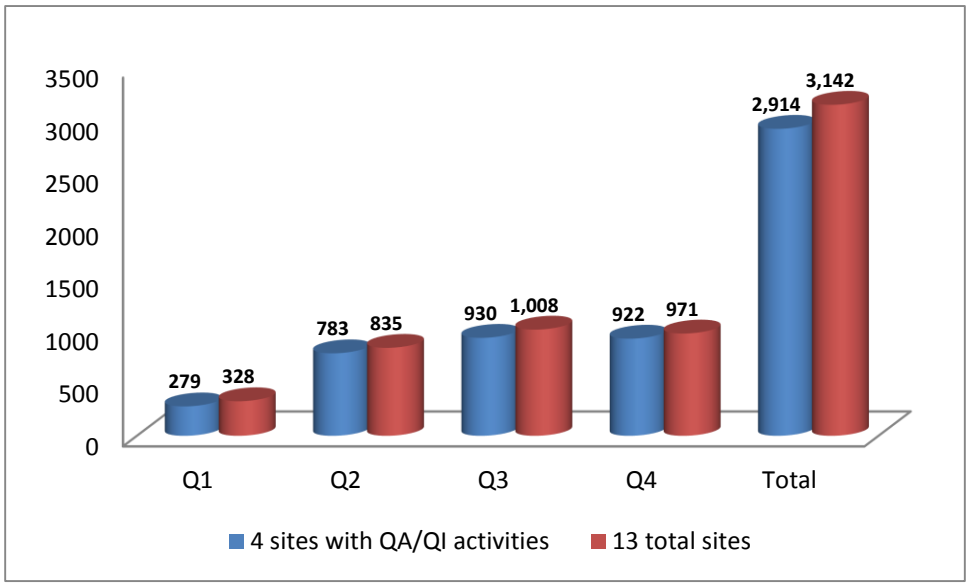


Figure 8. Contribution of QA/QI activities toward male involvement in 4 facilities (out of 13 total) in Kinshasa.



Activity 5: Develop and strengthen linkages to care and support and treatment services for HIV-positive pregnant women, their families, and OVC

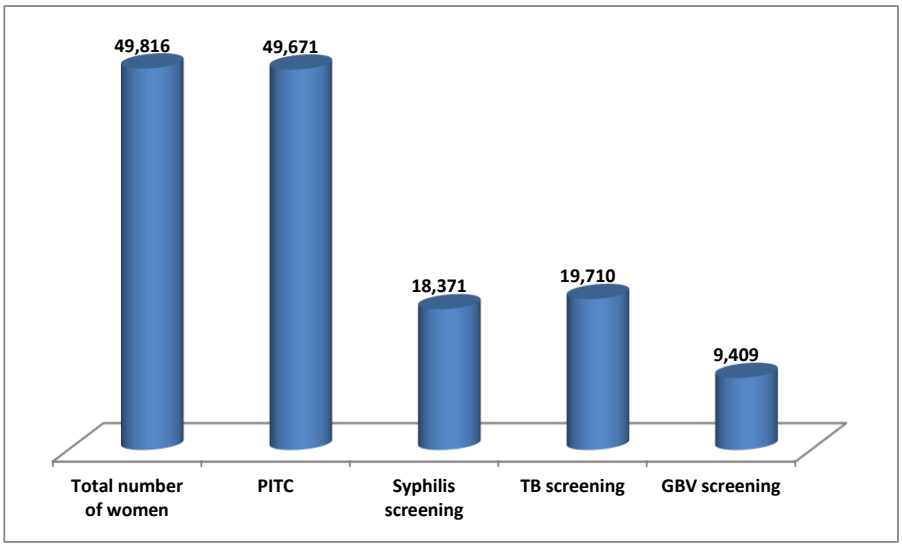
With the expansion of the service package provided to beneficiaries, ProVIC continued to strengthen the continuum of care for HIV-positive pregnant women and their families at many levels by reinforcing linkages to care and support and integrating PMTCT activities into

maternal and child health services. All pregnant women should receive family planning counseling, syphilis testing and treatment (for positive results), SGBV screening, and support or referral to specialized treatment units, TB screening and referral, and treatment (in the case of TB infection). HIV-positive women and their families were referred to support groups led by Mentor Mothers or to facility-based social workers for psychosocial support and/or for required medical attention, based on each client's needs.

HIV-exposed children on nevirapine prophylaxis at birth, following national protocol, were followed up for immunizations, early testing, cotrimoxazole initiation at six months after birth, and breastfeeding. In all health facilities, in addition to phone calls from providers to pregnant women and home visits for those who had not shown up to their appointments, other strategies, such as covering maternity fees for HIV-positive women, were used to reduce loss to follow-up.

Using a tool developed in Q2 that includes all indicators for ProVIC's integrated PMTCT/maternal, newborn, and child health (MNCH) activities for the continuum of care, ProVIC increased the number of pregnant women and their families receiving services along the continuum of care and support. Figure 9 highlights efforts to provide MNCH services to pregnant women. Begun in Q2, results are encouraging, and efforts must continue in FY2014.

Figure 9. MNCH interventions for pregnant women by entry point.



GBV: gender-based violence. SGBV activities are implemented only in Kinshasa and Province Orientale.

Activity 6: Ensure coaching and mentorship for integrated PMTCT services offered through the PMTCT platform

ProVIC developed a management tool in Q3 which includes all indicators for ProVIC's integrated activities in the continuum of care and allows for improved coordination of activities in health facilities, as all these services are a complex set of interventions that take place at multiple levels of the health care system. ProVIC teams developed a list of indicators that highlight aspects of integrated services, including strengths and weaknesses in the provision of

comprehensive integrated services. This information will lead to improved decision-making to strengthen identified weaknesses (through onsite mentoring).

ProVIC used this tool for improving follow-up of activities during supervision visits and to better ensure service quality standards at project-supported sites. Table 8 shows the number of health facilities providing the continuum of services by type of services and province. These tool and collaborative meetings contributed to improve the quality of the continuum of services offered in the health facilities, as described in Activity 4 above.

Table 8. Number of ProVIC-supported health facilities providing the continuum of services in FY2013.

Province	Health Zones	Health facilities	PITC	PMTCT	Adult ART	Pediatric ART	Family planning	TB screening	SBGV	Health support groups	Mentor Mother approach	Child-to-Child approach	OVC care
Kinshasa	5	13	13	13	13	2	13	13	13	72	2	82	13
Katanga	12	52	52	52	52	2	52	52	52	48	2	40	52
Orientale	5	20	20	20	20	1	20	20	20	7	2	7	20
Bas-Congo	5	18	18	18	18	0	18	18	0	35	0	0	18
Total	**27**	**103**	**103**	**103**	**103**	**5**	**103**	**103**	**85**	**162**	**6**	**129**	**103**

Activity 7: Reinforce the capacity of the government at all levels to provide comprehensive PMTCT services

In FY2013, ProVIC participated in meetings organized by the MOH, including the PMTCT Technical Working Group (TWG) and MNCH Task Force, offering suggestions and constructive feedback to challenges raised (see Table 9). In addition, ProVIC helped validate national ARV and Option B+ standards, guidelines, and newly integrated tools; and collaborated with the MOH and with the technical support of C-Change to update the national PMTCT messages used in communities.

Table 9. ProVIC participation in national and PEPFAR meetings, FY2013.

Topics	Participants	Period
National meetings		
MNCH Task Force	MOH, PEPFAR implementing partners, NU staff	Quarterly (September 2012, March 2013, June 2013)
PMTCT TWG	MOH, PEPFAR implementing partners, NU staff	Quarterly (November 2012)
Performance-based financing	MOH PBF Unit staff, USAID, ProVIC	October 2012, January 2013, March 2013, June 2013, September 2013
Health Zone operational plan process	ProVIC and Health Zone	January 2013
Provincial data review	ProVIC, PNLS, PNSR, Health Zone	Quarterly
PEPFAR meetings		
Coordination	PEPFAR teams	Quarterly
Option B+ considerations	PEFPAR temporary duty team	June and September 2013

Comments on Year 4 results

Overall strong results show the quality improvement of PMTCT services provided in ProVIC-supported sites. ProVIC continued to work attentively with partners and Health Zones over the year to improve the quality of these services and to coach providers through the disclosure process.

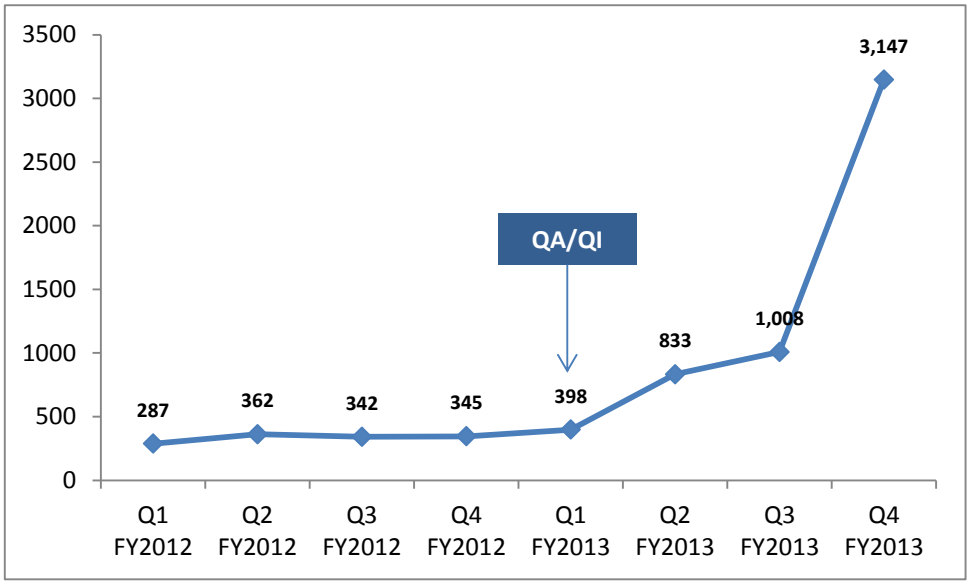
These results also show the positive effects of innovative approaches such as Mentor Mothers and the QA/QI collaborative. These two approaches contributed to improve the performance at health facilities, such as the return of HIV-pregnant women to deliver at a health facility and the involvement of male partners.

In addition, the number of pregnant women who were counseled and tested for HIV and who learned their results (52,585) represents an impressive 95% achievement against the project's annual target (55,251). The difference is due to the new sites having started activities late in the year (in Q4). The proportion of HIV-positive pregnant women on ARVs (84%) is also due to the late start of activities and may also be attributed to lack of coaching of providers during Q4.

Early screening of exposed infants is already well managed by providers, as is the initiation of exposed infants on cotrimoxazole at six weeks old. These indicators appear weak in the cascade due to long periods of DBS kit shortages (specifically collection papers) at sites.

Male involvement in PMTCT continued to improve through the mechanisms implemented by quality improvement teams mainly in Kinshasa, where we noted that of a total of 4,682 for all ProVIC-supported sites, 3,147 (67%) were tested where QA/QI activities were being implemented (Figure 10).

Figure 10. Contribution of the QA/QI collaborative approach to the number of male partners tested for HIV.



The services offered to male partners continued to improve as well. The 3,147 total in Figure 10 represents 16% of the annual target of 20%. HIV-positive male partners are immunologically evaluated and put on ARVs if eligible. Ineligible individuals receive cotrimoxazole. Screening and provision of care and support of other family members of HIV-positive pregnant women also improved over the year.

Analysis of continuum of care in health facilities for FY2013

Table 10 shows that during ANC services, 18,371 pregnant women were tested for syphilis and 70 positive cases were identified and treated, along with their male partners, according to PNLS guidelines. A total of 19,710 pregnant women (both HIV positive and negative) were screened for TB, and 9,409 pregnant women (both HIV positive and negative) were screened for SGBV (in the two provinces where ProVIC has been implementing the approach: Kinshasa and Province Orientale).

Table 10. Continuum of services for all PMTCT clients.

Target	Intervention				
	PITC	Syphilis screening	Syphilis positive	TB screening	GBV screening
Pregnant women	52,585	18,371	70	19,710	9,409
Male partners	4,682				
Other family members	123				

GBV: gender-based violence.

Table 11 illustrates how individuals who tested HIV positive, including pregnant women, their male partners, and other family members, and HIV-exposed infants are benefiting from the continuum of care services and support package.

Table 11. Continuum of care for HIV-positive individuals.

Target	Total	Intervention							
		CD4	CTX	AZT	ART	NVP	EID	Ped Tx	FP
HIV-positive pregnant women	1,381	1,025	1,009	736	434				20
HIV-positive male partners	98	11	7		9				
HIV-exposed infants	789		121			788	669	4	
Other HIV-positive family members	7	2	7		0			0	

AZT: zidovudine; **CTX:** cotrimoxazole; **EID:** early infant diagnosis; **FP:** family planning; **NVP:** nevirapine;

Based on these achievements, ProVIC, providing support in the implementation of comprehensive PMTCT activities including treatment of eligible individuals, aligns with the family approach advocated by the DRC government and contributes to the achievement of the objective of an "AIDS-free generation."

Intermediate Result 2: Care, support, and treatment for people living with HIV/AIDS and for orphans and vulnerable children improved in target areas

Overview

To date, ProVIC has established community structures and interventions to strengthen provision of care and support to adults and children infected and affected by HIV through self-help groups, Child-to-Child (C2C) groups, referral systems, palliative care services, nutritional support, access to schools, and increased access to legal support.

Based on USAID/DRC's Strategic Pivot priorities, ProVIC's care and support activities have focused on the core activities of retention and adherence to treatment, Prevention with Positives, cotrimoxazole preventive therapy, and TB screening and referrals since April 2013. Ensuring the quality of the different components of care and support work is critical to meet the expectations of the new Strategic Pivot, which recommends implementation of a continuum of care.

Supporting and reinforcing care and support service provision, and improving linkages and referrals between communities and health facilities, has been a key focus of Year 4, including the rollout of a detailed set of networking and linking activities to ensure that ProVIC's community-based services and existing health structures are synchronized and mutually supportive. ProVIC has worked to advance its QA/QI collaborative to improve referrals and counter-referrals, both internal to individual health facilities and external to other providers and community members. The table below highlights the achievements within Intermediate Result 2 during Year 4.

Table 12. Year 4 achievements under the care and support component.

PEPFAR indicator	Annual target	Achieve-ment	Percent of target
C1.1.D Number of eligible adults and children provided with a minimum of one care service	18,320	20,812	114%
C2.1.D Number of HIV-positive adults and children receiving a minimum of one clinical service	8,683	10,581	122%
C2.2.D Percentage of HIV-positive persons receiving cotrimoxazole prophylaxis	7,224	7,953	110%
C2.4.D Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings	5,924	8,375	141%
C2.5.D Percentage of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	1,196	1,567	131%
P7.1.D Number of PLWHA reached with a minimum package of prevention with PLWHA interventions	4,736	3,657	77%
C5.1.D Number of eligible clients who received food and/or other nutrition services	6,790	5,987	88%
C5.3.D Number of eligible children provided with health care referral	1,807	1,693	94%
C5.4.D Number of eligible children provided with educational and/or vocational training	3,000	2,427	81%
C5.5.D Number of eligible adults and children provided with protection and legal aid services	164	38	23%
C5.6.D Number of eligible adults and children provided with psychological, social, or spiritual support	17,346	16,142	93%

During Year 4, the care and support component achieved significant results that reflect the desire to provide a continuum of services to PLWHA and OVC, taking into consideration PEPFAR guidelines and Strategic Pivot recommendations on PMTCT. The care and support component has combined several strategies, including strengthening self-help and C2C groups through monthly meetings on topics that include the importance and side effects of cotrimoxazole, TB, personal hygiene, environmental hygiene, nutritional education, prevention of opportunist infections, and STIs. The Mentor Mother approach and the village savings and loan association (VSLA) model have been introduced to reinforce linkages between the community and clinical services as well as to contribute to community resilience and autonomy.

Sub-IR 2.1: Care and support services strengthened

Overview

The care, support, and treatment component of the project aims to promote the quality of life for HIV-positive pregnant and nursing women, their partners, and their children, most at-risk populations, young people at risk, and patients identified through testing through the provision of health facility-focused and high-quality clinical services.

The activities detailed below represent the PEPFAR guidance on the key elements of a strong care, support, and treatment program:

- Early identification of HIV-infected persons, linkage, and retention in care.
- Reduction in HIV-related morbidity and mortality.
- Improved quality of life.

Care and support activities have been integrated into all 103 ProVIC-supported health facilities. A key piece of the post-Strategic Pivot strategy has been the gradual shift from only community-based self-help groups to facility-based groups with community linkages. Health facility self-help groups are a central pillar to supporting the retention of PLWHA in care and to ensure referrals and counter-referrals with community self-help groups. Regular visits to health facilities has allowed ProVIC to observe that to date, 28 self-help groups have been integrated into health facilities in the different provinces. This includes nine in Kisangani, eight in Bas-Congo, seven in Katanga, and four in Kinshasa. This strategy of integration into health facilities will continue until the end of the project.

Following USAID recommendations, cotrimoxazole prophylaxis is now provided only at the clinic level.

The minimum package of Prevention with Positives has been integrated into health facilities. Monthly TB screening for all PLWHA during regular medical visits has also been integrated into health facilities, although this transition is proving challenging due to the large number of health staff who have yet to be trained in this approach.

Activities and achievements

Activity 1: Improve early identification of HIV-positive women among pregnant women, their male partners, and children, key populations, PITC clients, and at-risk youth, as well as linkages to and retention in care

With the Strategic Pivot, there has been increased focus on integration of the PMTCT, care, support, and treatment activities, which has led to improvement in providing HIV-positive pregnant women with the full range of critical services. For example, home visits, which contribute to early identification of HIV-positive family members, have been organized in a much more focused way than in the past, with the full involvement of Mentor Mothers, service providers, and social workers. These visits have been a vital step in encouraging greater uptake of testing among partners, children, and other family members, ensuring a family-centered approach. Facility-based self-help groups and their links to those existing in the community have facilitated referrals and counter-referrals between providers and the community. This has helped to improve retention in care throughout the continuum.

A follow-up session on maternal care and support activities at the Binza maternity in Kinshasa. *Photo: ProVIC*

For PMTCT clients, continuum of services through the care, support, and treatment cascade has enabled those who test positive to access the key elements of the minimum package of clinical services: cotrimoxazole, screening, diagnosis and treatment of TB, CD4 count, diagnosis and treatment of malnutrition, biological monitoring, ART, and positive prevention services for HIV-positive women who are seeking family planning services. Affected people (e.g., serodiscordant partners and children who tested negative after one or more parent tested positive) were supported through couples counseling, self-help group psychosocial support, and the identification and enrollment of children into the OVC program to ensure the family-centered approach.

Thanks to the diligent service of Mentor Mothers in the health facilities where they were trained, pregnant women, nursing mothers, male partners, and other PLWHA were better supported on psychosocial issues and made aware of how to best participate in facility and community self-help groups. The Mentor Mothers also helped to educate mothers to comply with preschool/under-five consultations, and they actively participated in the search for those clients who had fallen out of the cascade of care and treatment.

Several meetings between community and government partners were conducted in the provinces of Kinshasa, Bas-Congo, Sud Kivu, and Katanga in order to improve the referral and counter-referral systems to strengthen linkages between communities and health facilities. Directories of services developed under the lead of the Health Systems Strengthening Specialist were made available to all partners in communities and health facilities. These directories will be used to

facilitate referrals. Monitoring visits have enabled us to highlight the functionality and use of tools by health care providers and community workers.

Activity 2: Reduce the morbidity and mortality of PLWHA and their families through clinic-based care and support and community interventions

Provision of cotrimoxazole: Improvements were made in Year 4 in the provision of cotrimoxazole prophylaxis in accordance with PEPFAR guidelines while respecting national guidance. Cotrimoxazole stocks were repositioned in health facilities so that health care providers were accountable for management of stock provided by ProVIC. The positioning of cotrimoxazole in health facilities was accompanied by the designation of a focal point in charge of its management and distribution to PLWHA. This system has reinforced the traceability of the provision of cotrimoxazole. To comply with the recommendations of USAID, grantees were asked to collaborate with health care facilities to ensure cotrimoxazole was offered to all PLWHA, especially those clients who had previously obtained cotrimoxazole at the community level.

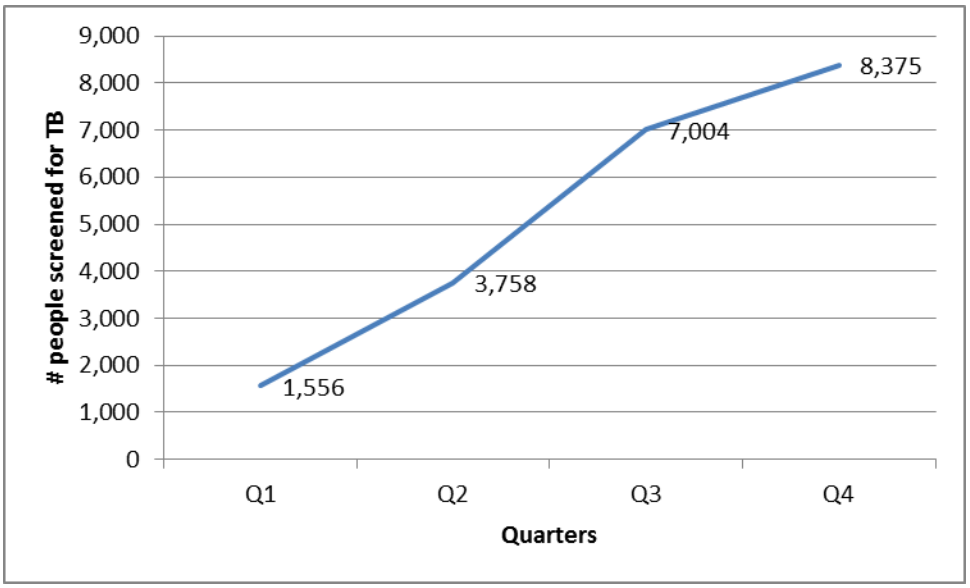
On-the-ground follow-up in Q3 and Q4 confirmed that all PLWHA receiving cotrimoxazole prophylaxis were doing so at health facilities. The importance of regular adherence to cotrimoxazole is also the subject of discussion in self-help groups at both the facility and community levels. Discussion and understanding of the side effects of cotrimoxazole allow for quick referral of PLWHA suffering from any symptoms. To better coordinate this activity, Health Zone Chief Medical Officers were informed of the transition of the supply of cotrimoxazole to the health facilities. Cotrimoxazole stock was delivered to the central offices of the Health Zones for redeployment at the health facilities requiring additional stock.

TB screening, diagnosis, and treatment: After the weak performance in 2012 with regard to TB screening, concerted efforts have been made to adhere to PEPFAR guidelines, which recommend that all PLWHA receive TB screening. Very positive trends were achieved this year (see Figure 11).

In Q2, TB screening guidelines and a tool were shared with all ProVIC partners, communities, and health facilities. Screening of HIV-positive individuals for TB is now routine. For example, in Q3, a total of 79% of PLWHA were screened for TB, with a high number coming from self-help groups. All (100%) of those who tested positive received treatment, marking a significant improvement over the first half of the year, which recorded only 68% of TB-positive PLWHA receiving treatment.

All potential TB cases are referred to *Centre Santé Dépistage Tuberculose* (TB diagnostic and treatment sites), which is often a service offered in hospitals for diagnosis and medical care as appropriate. In TB cases, a home visit is carried out to raise awareness among family members who have been in contact with the TB patient.

Figure 11: Number of PLWHA screened for TB, by quarter.



Nutritional counseling through health system services: A key focus during Year 4 was training of caregivers to detect malnutrition and provide palliative care. ProVIC has provided nutritional support following the NACS (Nutrition Assessment, Counseling, and Support) approach, systematically referring suspected cases to Ambulatory Treatment Nutritional Units (UNTAs) and Intensive Treatment Nutritional Units (UNTIs), where PLWHA and OVC can access ready-to-use therapeutic food.

ProVIC has maintained contact with the Food and Nutrition Technical Assistance (FANTA) team for greater embedding of NACS in health facilities. FANTA has targeted two health facilities supported by ProVIC to pilot the NACS approach (Kikimi and Mbakana Hospital Centers). As prerequisites for the introduction of NACS, training modules have been validated under the lead of *Programme National Intégré d'Alimentation et de Nutrition* with FANTA funding. Also, ProVIC supported and participated in the validation workshop of the nutritional care of PLWHA guide, which will support health care providers in addressing issues of nutritional counseling.

Vaccination of children of HIV-positive mothers: The importance of monitoring the immunization schedule of infants of HIV-positive mothers was included in the site visits. The goal is to reduce loss to immunization by addressing key areas, including:

- Awareness-raising among mothers during medical appointments of the importance of immunization.
- Monitoring of compliance for exposed preschool children and actively searching for children lost to follow-up.
- Awareness-raising around the importance of immunization among lactating women and male partners and other family members during self-help group meetings.

- Using children in C2C groups to act as "relays" for the dissemination of messages to parents regarding the importance of monitoring their children's immunization schedules.
- Ensuring participation of children in various vaccination campaigns organized by the government.

Self-help group meeting in Kinkenda Champion Community, Kinshasa.

ARV treatment of newborns and HIV-positive adults: Please see Sub-IR 2.3 for further details.

CD4 count management and biological follow-up: Biological follow-up remains a challenge. Currently, these services (blood, liver, and kidney tests and chest x-ray) require payment, which means they are not readily accessible to all clients. However, thanks to collaborative agreements, these examinations will be provided free of charge for PLWHA tested and receiving treatment in ProVIC health facilities. This process was initiated in Year 4 and will be expanded in Year 5 to additional ProVIC-supported Health Zones as they obtain the necessary equipment.

A follow-up session with a nurse as part of a mentoring and monitoring visit to Kikimi Hospital Center. *Photo: ProVIC*

Monitoring children after the 9th and 18th months for testing remains a challenge. Many have dropped out of the cascade of care by this stage and it is not always easy to maintain consistent follow-up. But efforts have been made to reduce the number of children dropping out by maintaining communication (phone, home visits) using Mentor Mothers and social workers.

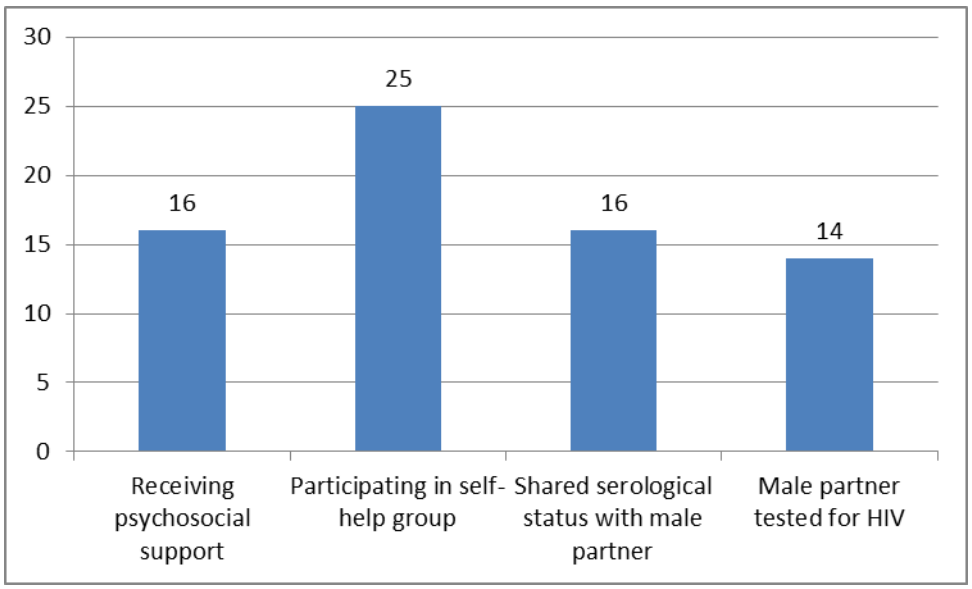
Minimum package of Prevention with Positives: In Year 4, 3,344 PLWHA received the minimum package of Prevention with Positives. In Q1 and Q2, the main positive prevention interventions were available at the community level, but per the Strategic Pivot, beginning in Q3, significant improvement has been made in increasing the availability of positive prevention services in clinical settings. Community-level roles have changed from service provision to informing, advising, and referring PLWHA to health facilities when needed. ProVIC no longer counts positive prevention interventions at the community level in its results, although the activity continues in self-help groups, as it is seen to be an important and effective intervention in reaching PLWHA.

Activity 3: Improve the quality of life of PLWHA

Self-help groups, based both at the community and clinic levels, contribute to improvements in the quality of life for PLWHA. To date, 162 self-help groups are operating in champion communities, with an average of 25 members per group (72 in Kinshasa, 48 in Katanga, 35 in Bas-Congo, and seven in Province Orientale). In these self-help groups, a variety of topics are discussed between PLWHA and health providers: positive prevention, the importance of TB screening, adherence to ART, personal and environmental hygiene, good nutrition and food security, and modes of transmission of HIV.

Another important strategy to improve the quality of life for PLWHA includes the Mentor Mother approach. Please refer to details in Sub-IR 1.3. Figure 12 shows positive results from health facility data analysis in Q3 related mainly to the retention of HIV-positive women with the Mentor Mother approach. The data from Kisangani shows how all HIV-positive women are supported through the approach by mentor mothers, self-help groups, and inclusion of their male partners.

Figure 12. Mentor Mother Approach cascade from 2 facilities in Kisangani: Among 16 HIV+ pregnant women



Development of key messages on Positive Health, Dignity, and Prevention: Since the third year of the project, ProVIC has worked with the support of C-Change on the development of key messages for the Positive Health, Dignity, and Prevention process. The aim is to provide service providers with visual aids in the form of counseling cards and picture boxes in order to facilitate interpersonal communication with clients, with a view to changing behavior. This is a long process that has included the participation of the national and provincial governments. The Strategic Pivot has refocused messages around the PMTCT platform and included a strong component on gender-based violence (GBV). Materials will be pre-tested in two sites in November 2013.

Strengthening of economic support: The income-generating activities financed in 2012 aimed to mitigate the economic impact of HIV on families of PLWHA and OVC. The project has supported income-generating activities focused mainly on small business trade, such as sewing, livestock-raising, farming, and gardening. This means that grantees have tried as much as possible to diversify the activities for which they have received support from individual or collective PLWHA. In addition, most PLWHA are linked with microcredit institutions in order to benefit from the range of services that they supply.

Prior to the Strategic Pivot, ProVIC, with the support of USAID's Livelihood and Food Security Technical Assistance (LIFT) project, began the piloting of VSLA in selected champion communities throughout the project. In FY2013, 332 PLWHA accessed 18 VSLA services. Some clients have gone on to open bank accounts and deposit their savings in order to benefit from available microcredit schemes. Although it is too early to fully determine if these VSLAs can provide sustained economic support for PLWHA, the early signs are very encouraging and lessons learned from this pilot will be shared.

Provision of essential home-based care interventions through targeted home visits: With the addition of treatment to the overall package of ProVIC-supported services and guidance from USAID, home visits are being de-emphasized in large part. Nevertheless, in ProVIC's experience, home visits are critical to tracking PLWHA lost to follow-up, ART, and TB and cotrimoxazole adherence, as well to reach out to family members of PLWHA for targeted prevention (including HIV testing) services.

Manioc harvest to support PLWHA in Kinsundi, Bas-Congo.
Photo: ProVIC

Sub-IR 2.2: Care and support for OVC strengthened

Overview

In Year 4, the project focused its efforts on providing a continuum of care for OVC, including children identified through the PMTCT platform. Additionally, following the Strategic Pivot, USAID requested that ProVIC provide support to OVC identified by CDC and US Department of Defense (DOD) partners.

Another essential activity in Year 4 was the requalification of OVC in Kinshasa, Katanga, and Orientale. In Sud Kivu and Bas-Congo, where ProVIC has ended community-based activities, extensive consultations were held to identify programs that could continue to provide OVC services, but in large part, ProVIC was not able to complete this process successfully. For example, the Global Fund has small, set targets for OVC they can support in each of their Health Zones, so they are not in a position to take on additional OVC. Despite such challenges, many Champion Community structures, many of which are now registered as CBOs, continue to proactively monitor OVC and seek solutions on a case-by-case basis. While these efforts are

nascent at this stage, this is a necessary and anticipated step to long-term sustainability of OVC support activities using locally available community resources.

In Year 4, 10,126 OVC received at least one care service, 2,885 had access to food and nutritional services, 1,693 benefited from medical referral, 2,427 were supported with education and vocational training, 38 were supported for protection and legal services, and 8,601 received psychosocial and spiritual support. The relatively low number for protection and legal support is due to the de-prioritization of this kind of support by USAID and the subsequent termination of the partnership with *Centre Solidarité Nationale*.

Activities and achievements

Activity 1: Support families of eligible OVC to improve the overall health of OVC

Based on PEPFAR OVC guidance, the empowerment of families remains a priority, as they are the main providers of care for OVC. As such, ProVIC has contributed to supporting and strengthening the capacity of these families to better meet the needs of children through psychosocial support for adults, C2C groups, and increasing economic capacity to support income-generating activities through the introduction of the savings and loan options.

Psychosocial support to OVC and their families: Through these activities, 15,553 people (including 8,204 OVC) benefited from psychosocial, moral, and spiritual support. Interactions developed with social workers/community organizers, and the C2C and self-help groups have enabled OVC and PLWHA to voice their concerns, share their experiences, and receive advice.

Educational chat with OVC guardians, Kizola-, Kinshasa.

A C2C group in Kabondo, Kisangani.

Economic strengthening for families through income-generating activities and *Association Voluntaire epargne et Credit* services: To reduce vulnerability and the economic impact of HIV on families and enable them to meet the basic needs of their children, ProVIC continued to support income-generating activities and introduced a new approach called *Association Voluntaire epargne et Credit* (AVEC, Voluntary Associations and Savings Credit), in collaboration with LIFT. A total of 499 PLWHA and OVC (122% of target) received support for income-generating activities in Year 4.

Activity 2: Provide prevention services and support to eligible HIV-positive and HIV-negative OVC

Mentor Mothers have continued to refer HIV-positive pregnant and lactating women to health facility-based self-help groups. In Year 4, 478 women received such a referral. In this way, retention in care has been strengthened, making it easier for medical service providers to monitor pregnancy and childbirth, including pre- and postnatal care, vaccination, growth evaluation, maternal care advice, and baby nutrition.

Activity 3: Provide clinical services to HIV-positive OVC

ProVIC expanded its activities in Year 4 by adding 35 new health facilities and integrating the Mentor Mother approach in six additional health facilities. Records from counseling services provided by health care providers and Mentor Mothers in prenatal and postnatal care show that 478 HIV-positive pregnant women were enrolled in care and support services, 71 neonates underwent virological testing after two months, and 124 infants were tested after 12 months. In addition, 27.3% of infants of HIV-positive pregnant women began cotrimoxazole two months after birth and children who tested HIV positive were placed on pediatric treatment.

In the same period, ProVIC provided at least one clinical service to 958 HIV-positive children, 773 children were put on cotrimoxazole prophylaxis, and 495 children were screened for TB. HIV-positive pregnant and lactating women enrolled in self-help groups received advice on health and nutrition to better take care of their children. See Sub-IRs 1.3 and 2.3 for details.

Activity 4: Improve the nutritional status of OVC

The nutrition and food support for OVC focused on nutritional counseling and patient education as well as referral to UNTAs and UNTIs. A total of 3,102 PLWHA and 2,885 OVC received nutritional support during C2C and self-help group meetings. Children with suspected malnutrition were referred to UNTAs and UNTIs for screening and management.

Activity 5: Support OVC completion of primary school and emphasize support for female OVC to access secondary school

In Year 4, ProVIC facilitated access to education and vocational training for 2,427 OVC. In line with PEPFAR guidance, 50% of supported OVC have the opportunity to complete primary school. Fifty-six percent of the OVC supported for education were girls.

In addition, to increase the number of OVC enrolled for the 2013-2014 school year, ProVIC obtained authorization from USAID to pursue a partnership project with Caritas, which will help facilitate access to education and vocational training for 5,850 OVC in three priority provinces (Kinshasa, Katanga, and Orientale). Initial work including school mapping, OVC selection, and the signing of cooperative agreements with schools took place in Q4.

Activity 6: Requalification of ProVIC OVC and enrollment of OVC from CDC and DOD

Data analysis on OVC revealed some inconsistencies with regard to the initial cohort ProVIC inherited from the previous USAID project, AMITIÉ, such as inconsistent use of selection

criteria by NGO partners and insufficient assessment of the real needs of each beneficiary. Therefore, ProVIC began conducting an intensive re-analysis of the OVC cohort to ensure that children being targeted remain in need of services and/or have not moved out of the program area. As a result, requalification of OVC took place in Year 4 in Kinshasa, Katanga, and Province Orientale. The detailed analysis will continue in Year 5, to allow us to determine the status and vulnerability profile of each OVC to ensure that they remain engaged with the project and are able to access the services they need.

With the Strategic Pivot, PEPFAR turned to ProVIC to support OVC identified in health facilities of DOD- and CDC-supported partners. The activity was highly collaborative, but complex, due in part to the limited capacity of CDC and DOD partners to identify OVC, and because ProVIC was required to determine what exactly was being requested as well as the best mechanism to pay for clinical care for OVC.

A form for the identification of OVC was developed and validated through a consultative process. ProVIC Kisangani has initiated the identification of OVC from *Association de Sante Familiale* (ASF)/Population Services International (PSI) and University of North Carolina partners. The current estimate is 140 OVC identified. These OVC are to be enrolled in the program to benefit from the package of services available. Work will continue into Year 5 for the remaining priority provinces.

Sub-IR 2.3: HIV treatment improved in target areas

Overview

In addition to the activities already integrated into the program—including early identification of exposed children; cotrimoxazole prophylaxis; and ARVs for pregnant women, their partners, and children exposed during the PMTCT period (from the moment an HIV-positive woman discovers she is pregnant up to complete cessation of breastfeeding)—ProVIC expanded its care interventions and supports lifelong ARV treatment for all PLWHA identified in the program. Thus, the window of opportunity for care and lifelong ART has been expanded in the third quarter to include all PLWHA: within key populations, patients attending sites or hospitalized patients, patients with STIs, TB patients, and those who are malnourished.

Activities and achievements

Activity 1: Conduct a baseline study of health facilities to identify needs for treatment-related services

To determine the existing HIV treatment interventions and stakeholders in ProVIC-supported health facilities, a baseline assessment was completed to address gaps in services related to ART and to ensure the integration of activities and the continuum of care for PLWHA who will be put on treatment. This assessment was essential to the development of ProVIC's contractual agreements with health facilities to finance these activities. The information from the baseline report was used to guide the writing of partner agreements, taking into account expected targets per site and per year.

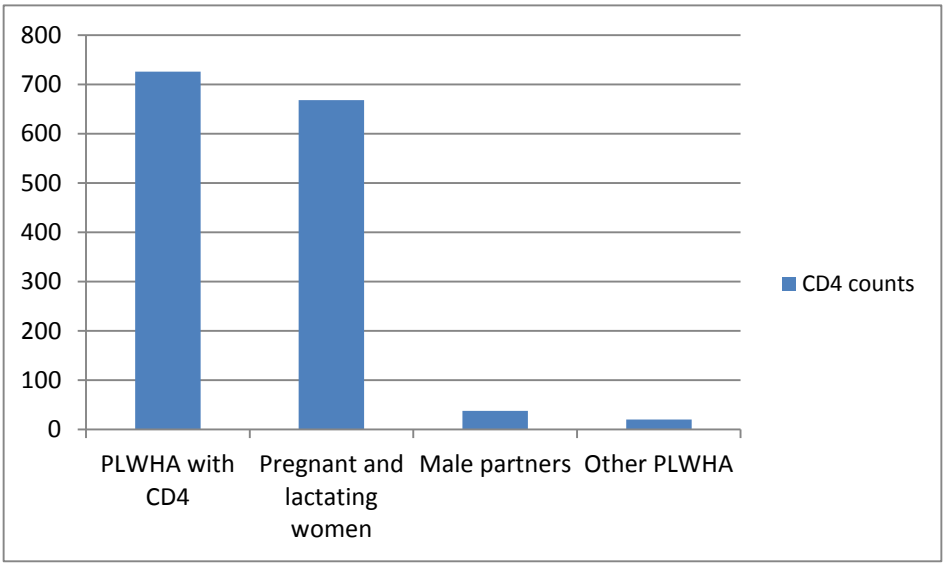
ProVIC administered questionnaires designed to collect key information regarding HIV treatment, especially pediatric treatment. The questionnaires were sent to HGR Kenya, HGR Sendwe, HGR Panda, and HGR Kasumbalesa in Katanga; CSR Mokili in Kisangani; and Kikimi and Kisangani Hospital Centers (including the Kisangani maternity ward) in Kinshasa. The findings showed that all seven sites are offering ART for adults. However, they are no longer providing ART to children; the reason given was lack of pediatric ARVs onsite (although we later learned that they were available). Biochemistry tests are not being performed at HGR Kasumbalesa. The cost of related health services was found to be substantial, with the fee for hepatic and renal analysis at $28 per patient and the cost for a ten-day hospital stay ranging from $30 to $80.

At the end of the assessment, six sites were identified as the first set of future ProVIC pediatric care sites, three in Katanga (HGR Kenya, HGR Panda, and HGR Kasumbalesa), two in Kinshasa (Kisangani maternity and Kikimi Hospital Center), and one in Kisangani (CSR Mokili). The managing officers of these sites expressed their satisfaction with the ProVIC approach aimed at increasing its intervention package within the same site, which will decrease the number of patients lost to follow-up due to having to walk a distance of several kilometers to receive care, particularly pediatric ART.

Activity 2: Introduce necessary laboratory testing for PLWHA

A total of 1,351 PLWHA were identified in Year 4, and CD4 count was performed for 726 PLWHA: 668 pregnant and lactating women, 38 male partners, and 20 other PLWHA (Figure 13). The PIMA™ Analysers for CD4 count are located in the central sites, and peripheral sites are transferring samples for assay. Of the 726 PLWHA offered CD4 counts, 381 had a count of ≤350 and received lifelong ART, including 366 pregnant and lactating women.

Figure 13. CD4 counts at ProVIC-supported sites, Year 4.

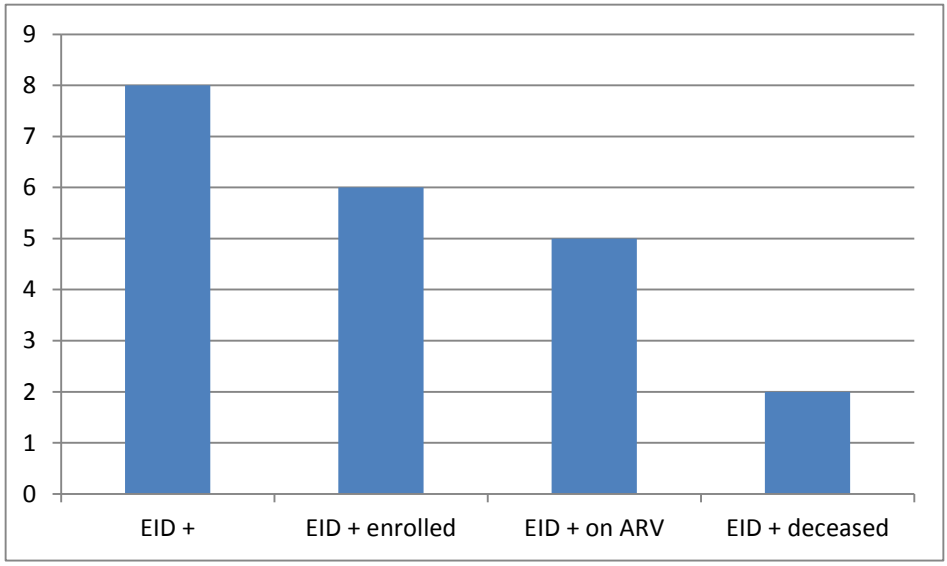


Activity 3: Ensure treatment for clinically eligible PLWHA at all supported Hub/Spoke clusters

In ProVIC-supported health facilities, eligible patients presenting with clinical stage III or IV and/or a CD4 count of ≤350 received AZT + 3TC + NVP as first-line regimen. In all, 1,351 PLWHA were identified in different ProVIC-supported health facilities, and taking into account the clinical stage of CD4 ≤350 and Option B+, a total of 441 received lifelong ART, including 414 pregnant and/or lactating women.

Eight children at two sites were identified early as HIV positive through DNA polymerase chain reaction testing (Figure 14). Three were born to mothers who were identified in the third trimester of pregnancy and who had poor adherence. Two children died before receiving the laboratory results (the time to receive test results has, at times, exceeded two months).

Figure 14. Infants screened positive and started on ARVs under ProVIC in Year 4.

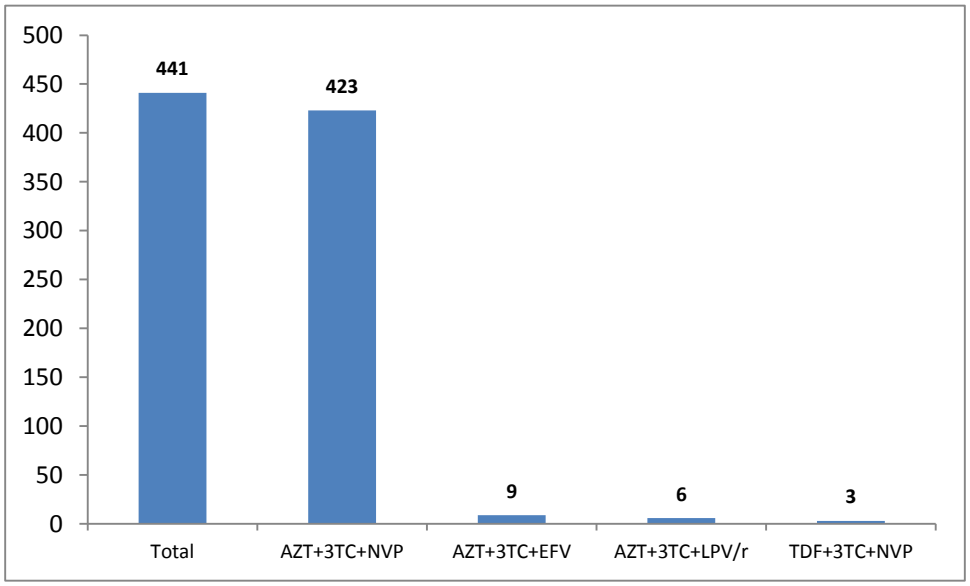


EID: early infant diagnosis.

Thanks to the collaboration with the Clinton Foundation, pediatric ARVs were made available for ART at the same sites where these children were screened, and at sites where their mothers also receive treatment. Of the six living children, five are on ART adherence counseling.

To date, 441 PLWHA are on ART; 423 are receiving AZT + 3TC + NVP; nine are receiving AZT + 3TC + EFV; six take AZT + 3TC + LPV/r; and three are on TDF + 3TC + NVP (Figure 14). No major side effects or drug intolerance requiring hospitalization have been reported.

Figure 15. ARV regimens for PLWHA at ProVIC-supported sites in Year 4.



Activity 4: Ensure access to an extended continuum of care package for PLWHA

To investigate major opportunistic infections, particularly TB, providers used the screening tool containing key questions regarding symptoms, notably persisting fever, cough lasting more than two weeks, wasting, and night sweats. HIV-positive patients testing positive for TB were initiated on TB treatment before ART, in accordance with DRC's current national protocol for TB/HIV. Patients with STIs were treated following the syndromic approach, as recommended by the PNLS.

Intermediate Result 3: Strengthening of health systems supported

Overview

ProVIC's health systems strengthening component contributes to strengthening DRC's health systems in order to support long-lasting impact on the program beneficiaries.

Activities implemented at the national level in FY2013 included financial and technical support provided to the PNLS. At the provincial level, support was provided to provincial partners in the areas of coordination and leadership, addressing gaps and making the system more functional and better able to provide a more effective response to the HIV epidemic. Some activities were also implemented at the operational Health Zone level, ensuring that program activities within Health Zones were tracked closely by the DRC government's health system.

In Year 4, ProVIC established a collaborative agreement with each Health Zone in which it operates. These accords provide support for coordination and communication and clearly state the responsibility and commitment of the Health Zone to ensure the follow-up of its referral system and to track lost patients. ProVIC has been monitoring the use of referral and counter-referral forms, which steadily improved throughout Year 4.

Sub-IR 3.1: Capacity of provincial government health systems supported

Overview

Health Zones remain the operational units for all program implementation. Following USAID's recommendation to further strengthen ProVIC's interventions within Health Zone leadership, the project signed collaborative agreements with selected Health Zones in order to deliver services. ProVIC has supported 34 Health Zones through these collaborative agreements, making them accountable for data validation, monitoring, referral and counter-referral, and supervision. ProVIC has provided desktop computers and communications supplies to fill gaps in all supported Health Zones, as well as modems for Internet connection and funding for monthly supervision, monitoring meetings, and phone cards.

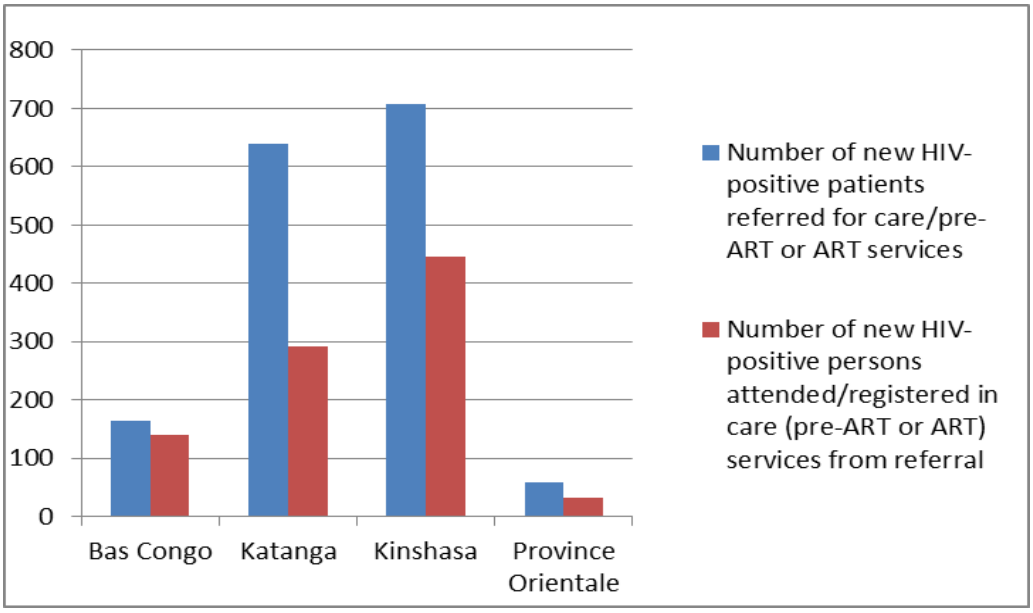
Activities and achievements

Activity 1: Strengthen referral and counter-referral systems

Clients' access to and use of services in health facilities prompted ProVIC to design a model network of HIV referrals and counter-referrals for clients. Progress was observed in the referral network in Year 4, with Health Zones becoming accountable for some critical referral issues.

The figure below shows referrals and registration for services based on referrals in four provinces: Bas-Congo, Katanga, Kinshasa, and Kisangani. Referral types and consistency vary widely by province; services for which clients receive referrals include adherence counseling, couple counseling, ART, PMTCT, TB screening, and food support. ProVIC will work with partners to continue to improve referrals and counter referrals.

Figure 16. ProVIC referral indicators, Year 4.



Activity 2: Support the government's supervisory role at all levels

During the last quarter, ProVIC supported a joint supervisory visit to the Health Zones in each province. DRC government partners, the PNLS, PNMLS, PNSR, and DVGFAE were involved in providing integrated supervision to the service providers in Kisangani. In Katanga, Sud Kivu, and Bas-Congo, the PNLS, PNMLS, and PNSR worked together to ensure these supervisions took place.

ProVIC also supported national-level supervision of the PNLMS and PNLS to ProVIC sites in Katanga Province. The PNMLS National Executive Secretary and the PNLS Director accompanied ProVIC's Chief of Party to Lubumbashi, Kasumbalesa, Luisha, and Fungurume to visit champion communities and several health facilities.

Activity 3: Support leadership-building activities within project interventions

ProVIC provided support to the PNMLS for quarterly provincial coordination meetings with partners involved in HIV programs.

A financial contribution was provided to the Provincial Health Division and PNLS to organize the annual planning workshop in all provinces.

As described under Sub-IR 1.2, the PNLS received financial support from ProVIC to organize a workshop to develop PITC training modules.

Activity 4: Build the capacity of health care providers to deliver an integrated package of HIV services

During Q3 and Q4, as part of the PMTCT platform orientation, ProVIC worked with the PNLS to develop an integrated training model and then train service providers in Kinshasa, Orientale, and Katanga. These trainings were designed to cover new sites in order to extend the coverage of PMTCT services, as well as to bring sites previously supported within the PMTCT package up to standard on treatment protocol.

In total, 659 service providers, including doctors, nurses, laboratory technicians, community workers, social workers, and warehouse managers, were trained in order to develop their skills in delivering prevention, care, and treatment services.

Information on training was also uploaded on TraiNet, USAID's database of trainings delivered by ProVIC with US funding.

Activity 5: Support commodity management in Health Zones

ProVIC has gradually shifted management of its commodities to increasingly relying on existing government structures, as these structures have been supported to grow their own capacity. For example, ProVIC now uses *Centre de Distribution Regional* facilities in Bas-Congo, Kinshasa, and Kisangani to warehouse its commodities. This has been a gradual process, as the improvement of quality control standards in these facilities has been slow.

Stock management was emphasized in selected Health Zones to improve coordination of HIV supplies in health facilities.

ProVIC has identified the need for closer supervision of pharmacists in government sites. While all these individuals have been trained and provided with all the required tools to manage their commodity stocks, many do not complete the work as required. ProVIC has sought to improve management through closer supervision of these health facility pharmacists, particularly in Kinshasa and Katanga, where a Logistics Officer was added in Year 4 to support the expanding number of health facilities supported by the project.

Pharmacists and warehouse managers in new sites were trained on stock management in the health facilities in selected Health Zones as part of the integrated training described above.

In order to improve data collection for better commodity management in the provinces, a feature was developed for ProVIC's database that will link commodities delivered with results from specific sites.

Activity 6: Reproduce and disseminate tools, manuals, and policy documents associated with ProVIC's interventions

In order to improve the quality of services, there was an urgent need to make data collection tools available in new and existing sites, a function that would normally be taken on by the PNLS but which they are not consistently available to complete. The following tools (see table below) were reproduced and distributed in the provinces.

Table 12. Data collection tools available in project-supported provinces.

Tool	Province				Total
	Kinshasa	Katanga	Kisangani	Bas-Congo	
Partogram form	1,350	4,200	1,850	600	8,000
Postnatal consultation form	1,350	4,200	1,850	600	8,000
Antenatal register	25	50	33	12	120
Delivery room register	25	50	33	12	120
Family planning register	30	40	15	15	100
Family planning form	30	40	15	15	100
Sexual violence file	30	40	30	0	100
GBV register	10	20	10	0	40

The data collected via these tools feed into ProVIC's monitoring and evaluation (M&E) system and contribute to the DRC government's data collection process; data are shared with the Health Zones, which then feed the data up to the provincial level.

Activity 7: Support integrated supervision at the Health Zone level

Collaborative agreements are in place in supported Health Zones. As a result, ProVIC has been able to work with the Health Zones to support them to ensure closer supervision of all facilities within each zone. Eleven Health Zones in Kinshasa, six in Bas-Congo, five in Sud Kivu, four in Orientale, and ten in Katanga reported on monthly supervision and monitoring meetings.

Sub-IR 3.2: Capacity of nongovernmental providers improved

Activity 1: Strengthen the organizational capacity of partner NGOs

In response to the Strategic Pivot, the NGO capacity-building component has been greatly reduced. However, in FY2013, ProVIC assisted implementing partners to update their administration and financial manuals, as well as providing mentoring and coaching in managing their grants and financial systems. Most of this work was done through field visits to ensure that implementing partners make better use of written documents in practice.

Sub-IR 3.3: Strategic information systems at the community and facility levels strengthened

Overview

Year 4 brought a substantial increase in the volume of data collected by the project—due to the addition of new local public and private health facility partners, the engagement of Health Zone partners, and the addition of new PEPFAR and project indicators. The Strategic Pivot has placed significant demands on, and required architectural changes to, ProVIC's M&E system.

To make the needed updates to ProVIC's data collection and reporting system, the M&E team consulted with USAID, PEPFAR, the DRC government, local partners, and the project's technical and M&E Specialists; updated ProVIC's online M&E database system, with short-term technical assistance from the project's database consultant; and trained M&E focal points from both existing and new health facilities on the new, post-Pivot datacards.

Throughout, while ProVIC's M&E team has helped champion the large, coordinated response to these dynamic, rapidly evolving demands, they have also continued to help strengthen the M&E systems and capacities of local counterparts. From conducting routine data quality assurance (RDQA) and joint supervision visits to working with the government to improve its national health information system, ProVIC's M&E team has worked closely with project and NGO staff, health providers, and government M&E leads to more regularly collect, analyze, deploy, and improve data to inform decision-making at both the project and health system levels—locally, regionally, and nationally.

Project documents such as the Performance Monitoring and Evaluation Plan (PMEP) and 2013 Country Operational Plan (COP13) were reviewed and updated this year. To align with the Pivot Strategy, reviewing the PMEP focused on appropriate indicators for monitoring the continuum of care and reviewing the COP13 focused on setting realistic, achievable annual targets. Two of ProVIC's M&E team leaders attended the PEPFAR-organized workshop to set COP13 and COP14 targets in alignment with the Pivot Strategy.

Activities and achievements

Activity 1: Strengthen ProVIC's M&E system through ongoing coordination with other technical areas

ProVIC's national and provincial M&E teams conducted monthly site visits that included:

- Working to ensure the availability and correct use of data collection tools and M&E datacards.
- Strengthening local partners' understanding of all indicators in the PMTCT service cascade.
- Convening follow-up discussions with local partners on progress against these indicators.
- Following up on recommendations that emerged during RDQA exercises completed in 2012.

In Sud Kivu, every local implementing partner received at least one visit per quarter over the course of the first semester. Some visits were made jointly with ProVIC's regional technical specialists (for each project component): three joint supervision visits with the Regional Prevention Specialist, and one joint supervision visit with the Regional Care and Support Specialist.

In Kisangani, the Regional M&E Specialist conducted six supportive supervision site visits, at two visits per month, to all health facilities newly engaged by ProVIC within the past year: CS Malkia wa Mushaidi, CS Mokili, CS Neema, CS Yabiso, CS Pumuzika, and CS Muungano. In collaboration with the provincial PNLS *Bureau Provincial de Coordination* in Kisangani, ProVIC's full complement of data collection tools (for PMTCT, HTC, GBV, sensitization, health systems strengthening, and care and support) were distributed to all project-supported health facilities in this region.

PMTCT data collection tools were updated by the PLNS with the ProVIC PMTCT team's technical support before being distributed in our supported sites. During a workshop led by ProVIC's National Pediatric Care Specialist, Regional M&E Specialist, and Chief Medical Officers from Ibanda Health Zone in Sud Kivu in November 2012, PMTCT health providers from project-supported sites learned how to complete the following tools in detail:

- Partogram, to record key maternal and fetal data during labor.
- Integrated prenatal consultation register (record).
- Integrated preschool consultation register.
- Registers for HIV-positive women and for their male partners.
- Tracking sheets for HIV-exposed infants.

ProVIC's M&E Assistant participated in a workshop to develop the Mentor Mother approach guide, contributing mainly to the M&E module. The National M&E Specialist trained partners who will be implementing this approach.

To improve data around TB screening for improved diagnosis and treatment of TB in PLWHA, and to strengthen the accuracy and completeness of TB data reporting within the context of care

and support data, ProVIC's Care and Support and M&E teams championed efforts during the first quarter of Year 4 to develop, disseminate, and train local partners on these four new data collection tools:

- A home visit tracking tool.
- Self-help group tool.
- OVC enrollment sheet.
- Active TB case-tracking tool.

To ensure a strong, common understanding of additional project reporting requirements under the Strategic Pivot, ProVIC's National M&E Officer convened a one-week M&E system update workshop in Kinshasa in May for the project's entire M&E team. The Vera Solutions database consultant led an intensive, two-day session at the end of the week, focused on strengthening the capacity of ProVIC's national technical specialists, their assistants, and the entire M&E team to harness data from the online system to perform more rigorous data analysis. The consultant's travel and time were covered by non-ProVIC funds.

Activity 2: Provide M&E technical assistance to the PNMLS, PNLS, and Ministère des Affaires Sociales at the national and provincial levels

ProVIC's Bas-Congo and Sud Kivu M&E Specialists actively participated in reviewing and/or planning 2012 and 2013 activities organized by the PNLS during the reporting period. The project's Provincial M&E Specialists presented ProVIC data for each intervention component, which helped strengthen the government's understanding of the local HIV epidemics. During these annual, provincial-level coordination meetings, the project's planned interventions were also integrated into the 2013 *plans d'action operationels* (operational action plans) of the Health Zones in which ProVIC operates. As part of this effort to ensure harmonization and coordination of ProVIC-supported activities and health services with those of the local government, it is essential to make sure that clients are referred to HIV/AIDS services in a standardized manner.

In Kisangani, in collaboration with ProVIC's Regional Care and Support Specialist, the *Division des Affaires Sociales*, and local NGO partner Fondation Femme Plus, the project's Provincial M&E Specialist helped coordinate the development of an OVC identification tool and to establish an OVC database for improved follow-up this key population through the facility- and community-based continuum of care. More than 650 OVC were identified and recruited into ProVIC's care and support program in this province alone, through the launch and use of these tools.

ProVIC's Provincial M&E Specialists participated in first-quarter project review and second-quarter planning workshops. During these workshops, the project team and local implementing partners—including ProVIC's grantees and representatives from relevant Health Zone bureaus—collaborated closely to evaluate project performance and refine planning efforts. In some areas, this included identifying service and/or performance gaps, and then developing targeted catch-up plans that helped shape activity plans.

As another form of technical capacity-building support to provincial-level government health ministries, ProVIC's Kisangani M&E Specialist participated in Provincial Task Force meetings convened by the PNMLS. During these meetings, he contributed to validation of the provincial PNMLS 2012 annual HIV/AIDS report.

During Year 4, ProVIC was very active in sharing project data with government partners and contributing to increased understanding of DRC's HIV/AIDS epidemic. Joint data validation discussions at both the national and provincial levels notably reflected a strong, common interest in the project's data on key populations (e.g., SWs and MSM), for whom critical information gaps in HIV prevalence data persist. Highlights included:

- At the national level, ProVIC's National M&E Officer participated in a two-day workshop on the country's epidemiological profile. During this workshop, organized by the PNMLS and held at the PNLS offices, ProVIC presented a wealth of HIV programming data from its database. Particular attention was dedicated to discussing data on key populations.
- ProVIC's National M&E Specialist participated in National Task Force meetings on the Global AIDS Response Progress (GARP). As a result, ProVIC's programmatic data regarding SWs and MSM were included in the DRC GARP.
- ProVIC's Bas-Congo M&E Officer participated in a meeting of the *Cadre de Concertation Multisectoriel de Lutte contre le SIDA* (Framework for Multisectoral Cooperation against HIV/AIDS), organized by the PNMLS provincial bureau with ProVIC's financial support. During the meeting, held at the WHO offices, the M&E Officer presented ProVIC's second-quarter M&E project data, focusing on MSM-related data at the request of the PNMLS. ProVIC's MSM-targeted activities in Bas-Congo were recognized as both unprecedented and innovative by the provincial DRC government, which plans to publish a quarterly bulletin to share these data.
- In Kisangani, ProVIC's M&E Officer participated in an HIV/AIDS Task Force meeting convened by the PNMLS. This meeting served to jointly validate the project's first-quarter data. As with the above-mentioned meetings, participants were especially interested in ProVIC's data on key populations.

Activity 3: Improve implementing partners' capacity to conduct quality improvement and provide high-quality services

In December 2012, in collaboration with the PNLS, ProVIC and URC organized a three-day workshop on quality assurance. The targeted participants of this workshop included government technical staff and ProVIC's M&E team, which sent three participants to acquire more knowledge of quality assurance and the collaborative approach to improving the quality of PMTCT services.

At the end of this training, a collaborative team conducted PMTCT quality assurance in four maternity hospitals in Kinshasa as a practical exercise. M&E team members participated as external coaches. In March 2013, an international consultant reported that the pilot phase proved promising. He encouraged scaling up quality assurance in other provinces and that each component use this approach to improve the quality of its activities.

Activity 4: Provide ongoing datacard technical support to implementing partners to improve M&E reporting

Since September 2012, ProVIC's M&E team has been working in close collaboration with the project's different national technical specialists to both develop and roll out a new GBV M&E datacard, and to progressively incorporate feedback solicited across all operating provinces from implementing partners, provincial- and national-level government stakeholders, USAID, and other key project stakeholders over the past year. The full complement of now six M&E datacards constitutes the heart of ProVIC's M&E reporting and synchronizes with the project's online M&E database.

The Strategic Pivot has created substantial, additional donor reporting demands on ProVIC's M&E system; for example, related to the new activities and services around monitoring and follow-up of TB diagnosis and treatment among PLWHA; diagnosis, treatment, and/or referral of project beneficiaries for STIs other than HIV; and ARV treatment for adults and children (i.e., no longer limited to ARV treatment only for mothers and their infants, within the context of PMTCT). The Pivot has also reinforced the need to ensure the M&E team's mastery in manipulating, extracting, and analyzing data from this expanding system. To address these critical needs and help ProVIC rapidly and effectively respond to new contractual and other reporting requirements, substantial additional revisions were made to the project's M&E datacards in collaboration with PATH's M&E database consultant. As noted above, the consultant co-led an M&E database capacity-building workshop for the project's M&E team and national technical specialists in May in order to:

- Review and ensure a strong, common understanding of M&E datacard updates, and new project reporting requirements resulting from the Strategic Pivot.
- Strengthen the team's capacity to use system-generated data to improve storytelling and inform project-level decision-making.
- Prepare to launch the new database system functionalities (i.e., basic commodities tracking).

Upon completing our rigorous, project-wide exercise to update datacards to address additional, post-Pivot reporting requirements, the ProVIC team quickly organized local partner trainings to roll out these updated data collection tools. In Q3, ProVIC organized datacard debriefings with M&E focal points from existing local partner organizations, including 15 participants in Kinshasa, 33 in Katanga, and 17 in Sud Kivu. For new (post-Pivot) health facilities, ProVIC's Regional M&E Officers trained M&E focal points in Katanga (21 people in Lubumbashi, 25 in Likasi, and 21 in Kolwezi), Orientale (47 people in Kisangani and 27 in Bunia), and Bas-Congo (12 people). Ten focal points were trained in Kamina in Q4. M&E focal points from new health facilities in Kinshasa will receive this training at the beginning of the next fiscal year. Regional M&E Specialists worked closely with focal points of new health facilities. Coaching and intensive follow-up were needed, particularly for M&E focal points who were not computer literate.

Activity 5: Reinforce implementing partners' M&E capacity through regular monitoring, RDQA, and internal audits

Throughout the reporting period, ProVIC's M&E team continued their focused commitment to monitoring and improving the quality of data reported both by our local implementing partners and by the project overall—whether through peer-to-peer capacity-building, routine monitoring visits, internal audits, or RDQA.

RDQA sessions were completed during this period in Sud Kivu, Bas-Congo, and Kinshasa. In Sud Kivu, this included a combination of NGO and health facility grantees—*Association Coopérative pour la Synergie Féminine*, *Association de Lutte pour la Défense des Droits de la Femme et de l'Enfant*, Fondation Femme Plus, and CS Malka wa Amani—and focused on five critical PMTCT and care and support PEPFAR indicators, in recognition of the project's increased emphasis on these service types. In Katanga, RDQA activities were suspended due to the grave health of ProVIC's Regional M&E Specialist.

Since the aforementioned RDQAs were completed, ProVIC has observed incremental improvements in the data quality of targeted project indicators among these audited partners. However, continued data quality-related shortcomings in Sud Kivu identified through these RDQA exercises remain in the following areas:

- Records management of sometimes very sensitive project data, related to both chronology and confidentiality.
- Rigorous understanding of how to track the project's cohort of care and support beneficiaries.
- Correct use and completion of certain current data collection tools.
- Rigorous tracking of the project's cohort of HIV-positive pregnant women and their HIV-exposed infants within the context of comprehensive PMTCT service delivery.

ProVIC's M&E team continues to work collaboratively with our partnering health providers, local governments, and project technical specialists to explore ways to address these challenges.

In Bas-Congo, local NGO partners PSSP, *Centre Maman Kinzembo* (CEMAKI), and *Jeunesse Active pour le Développement Intégré et lute contre le SIDA* were audited this reporting period using ProVIC's RDQA tools. Analysis revealed strikingly positive developments in data quality (in comparison to a previous RDQA) among both CEMAKI and PSSP.

In Kinshasa, ProVIC's now largest NGO grantee (operating in three provinces), Fondation Femme Plus, was audited at the end of the first quarter by the project's National M&E Specialist and M&E Assistant. RDQA findings revealed some M&E-related challenges, such as misused and/or incomplete data collection forms from sensitization sessions, and the unsystematic numbering of these sensitization sessions—which, in turn, affected proper completion of the "sensibilization" M&E datacards by Femme Plus. Noting these data collection and reporting errors during follow-up RDQA review meetings with Femme Plus—and importantly, pointing out how to correct these errors—has since sparked their concerted efforts to improve in these areas (as observed in this partner's second-quarter reporting).

ProVIC's Kisangani M&E Specialist had just been trained to perform RDQAs at the end of the reporting period, and RDQA activities in this region will be launched in the next fiscal year. In addition, four ProVIC-supported health facilities (CSR Mokili, CS St. Camille, CS Neema, and CS Muungano) received QA/QI trainings, and activities were then launched in these sites—expanding ProVIC's successful quality assurance and improvement activities beyond the project's initial pilot health facilities in Kinshasa.

In addition to these ongoing activities, ProVIC's M&E team continued to build local partners' capacity for quality improvement by participating in Health Zone data validation meetings, and by closely monitoring and providing hands-on support to partners as they began completing their new, post-Pivot datacards. In addition, with the Local Capacity Development (LCD) initiative, the Kinshasa M&E team supervised a *Réseau National des Organisations d'Assise Communautaire* C2C group in the Champion Community of Mafuta Kizola. This organization has benefited from the coaching of PSSP, which PSSP reported has significantly improved its capabilities in data management. We noted availability of data collection tools, and the tools were properly completed during the implementation of this activity. Before LCD, availability and completion of these tools were weaknesses of the organization.

SECTION 2: PROGRAM MANAGEMENT

Administration and finance

Administration

Administration/Operations activities and issues for Year 4 included:

- Closeout of the Bukavu regional office.
- Working to find a location for the Bunia sub-office.

Finance

Financial activities/issues during this past year included:

- Financial review by USAID: The USAID Mission in DRC conducted a financial review in ProVIC's Kinshasa office in April-May 2013.
- PATH internal audit: A routine internal annual audit was conducted by PATH/Nairobi in April 2013.
- The Field Accounting and Compliance team from Chemonics Headquarters in Washington, DC, conducted a project financial review in the Kinshasa, Katanga, and Matadi offices.

Staffing

The project added some new positions and replaced departed staff as follows:

- Bobwa Wanya Rodrigue started in April as Prevention Specialist in the Matadi office.
- Kabanga wa Kabanga Alexandre left Alliance as Care and Support Specialist to join Chemonics as Regional Coordinator for the Bukavu office.
- Mbayi Katungulu joined in May as Internal Controller.
- Nkoy Mwakanzal Hippolyte left Alliance as NGO Health Systems Strengthening Specialist to join Chemonics as Deputy Regional Coordinator for the Kinshasa office.
- Paul Ngoie Mwilambwe joined in April as Assistant Grants Manager for the Katanga office.
- Venant Cikobe Zihalirwa was promoted to Deputy M&E Officer and transferred from the Bukavu office to the Katanga office.
- Didier Kabwe started as PMTCT Specialist for the Katanga office.
- Hommel Kabeya Tshibadi was hired as Information Technology Manager, replacing Olivier Kabeya, who resigned.
- Fabien Mokumesi started as Kinshasa Regional Accountant, replacing Tryphon Mbadinga.

- Kusama Tshowa Bobette started as Secretary in Katanga, replacing Mamida Ngoie who was promoted to Office Manager.
- Ngoie Ngalula Jolie started as a cleaner in Katanga, replacing Jeannette Kanyembo.
- Jean Marc Makabuza was hired as Bukavu Office Manager, replacing Desire.
- Lubazi Muhiya Andre joined as a driver in Katanga.
- Mangaza Ngongo Mamie was hired as Secretary in Kisangani.
- Masudi Kazunguvu was hired as a driver in Bukavu.
- Mputu Kayembe Joelle joined as Project Assistant for the Kinshasa regional office.
- Mombo Chanty moved from Chemonics, as the Matadi Prevention Specialist, to become the Kisangani EGAPF PMTCT Supervisor.
- Joseph Mukandila was promoted from Kinshasa Project Assistant to Kisangani Office Manager.
- Francis Ntumba was promoted from Kinshasa Accountant Assistant to Kisangani Regional Accountant.
- Phaka Soki Lisette started as Secretary in Matadi, replacing Esperance Kawanga, who was promoted to the Office Manager position.
- Marcel Walo Losambo joined as Bukavu Prevention Specialist.
- Antoine Masekwe left the Logistics Assistant position in the Katanga office.
- Didier Kamerhe moved to Matadi as Regional Coordinator.
- Mado Sidiki vacated Matadi Grants Manager position.
- Efulu Belinga started as a cleaner in the Kisangani office.
- Hyacinthe Zamwangana was hired as the Katanga Regional Care and Support Specialist.
- Da Silva Mukelenge Kimasa joined as Kisangani Health Systems Strengthening Specialist.
- Albert Masheka Hongo left the Bukavu Regional Accountant position.
- Olivier Kabeya Shindano left the Kisangani Regional Care and Support position.

Grants management

ProVIC's grant portfolio increased significantly in Year 4, from just 35 local partners in FY2012 to 137 local partners in FY2013. These partners include 15 local NGOs, 50 private health facilities, 38 public health facilities, and 34 Health Zones across five provinces. ProVIC supported these local partners with nearly $2.97 million in financing in FY2013. In total:

- 15 standard grants were issued to local NGOs: $1,968,934.
- 50 fixed-obligation grants were issued to private/church-affiliated health facilities: $492,977.

- 38 collaborative accords were issued to public health facilities: $391,700.
- 34 collaborative accords were issued to public Health Zones: $115,845.

In response to the launch of the Strategic Pivot, ProVIC realigned its partner portfolio in the following ways to better adhere to USAID/PEPFAR's shift in direction:

- Expansion of activities to reach a greater number of HIV-positive pregnant women and their families with a complete package of PMTCT services.
- Phasing-down of partnerships and activities in Sud Kivu and Bas-Congo, both of which are no longer priority provinces for PEPFAR.
- Shifting to facility-based PITC activities in Bas-Congo.
- Closure of collaborative accords with Health Zones whose coordination does not center around project-support PMTCT health facilities.
- Modification of Champion Community activities conducted by NGOs to center operations around health facilities and focus community mobilization around PMTCT and treatment adherence.
- Reduction of NGO grantee budgets to reflect a Pivot-driven shift from community-based care and support to integrated, facility-based care and support activities.

Throughout this realignment process, ProVIC proactively communicated intended shifts to project partners, the DRC government, and other stakeholders in order to preserve the strong partnerships ProVIC has fostered over the past four years.

ProVIC also significantly expanded its grant portfolio by entering into 78 new partnerships with PMTCT sites in Year 4. New partners included 26 private health facilities, 18 public health facilities, and 34 public Health Zones in the provinces of Kinshasa, Orientale, Bas-Congo, and Katanga (see Tables 13 and 14 below). ProVIC also initiated a new collaboration with NGO Caritas to expand educational and vocational training support to OVC in Kinshasa, Orientale, and Katanga Provinces.

Table 13. New PMTCT private health facilities (fixed-obligation grants).

Region	Recipient	FY2013 funding
Kinshasa	Bolingani Health Center	$2,724.50
	Light Health Center	$2,680.75
	Trinite Kivuvu Health Center	$2,874.00
Katanga	Awadi Health Center	$3,678.67
	Moriah Health Center	$3,945.00
	Uzima Wetu Health Center, Kikula	$4,171.67
	Kalulwa Health Center	$3,770.67
	Yambala Health Center	$4,489.33
	La Grace Health Center	$3,682.33
	Kitotwe Health Reference Center	$3,582.00
	Mokambo Health Reference Center	$3,886.33
	Radem Gambela Health Reference Center	$4,066.33
	Sion Health Center	$4,070.33

Region	Recipient	FY2013 funding
	Kongolo Health Reference Center	$3,501.00
	Chisambo Health Center	$3,690.00
	Uzima Wetu Health Center, Dilala	$3,893.00
	Bumi Health Center	$5,700.67
	Methodiste Health Center	$4,171.67
Orientale	Celpa Health Referral Center	$5,213.33
	Bondeko Health Center	$4,441.67
	Maman Mwilu Health Center	$4,669.67
	Segama Health Center	$4,250.00
	Salama Health Center	$4,738.00
	Central Health Center	$3,621.50
	Nyakasanza Health Center	$3,311.25
	Kindia Health Center	$2,540.00
	Total	**$101,363.67**

Table 14. New public health facilities and Health Zones (collaborative accords).

Region	Recipient	FY2013 funding
Kinshasa	Ngapani Health Center	$3,131.50
	Tembo Health Center	$3,456.25
	Bumbu Health Zone	$3,750.00
	Binza Meteo Health Zone	$3,750.00
	Kikimi Health Zone	$3,750.00
	Kisangani Health Zone	$3,750.00
	Maluku II Health Zone	$3,750.00
	Masina II Health Zone	$3,750.00
	Biyela Health Zone	$3,750.00
	Kasa Vubu Health Zone	$3,750.00
	Masina I Health Zone	$3,750.00
	Matete Health Zone	$3,750.00
	Mont Ngafula II Health Zone	$3,750.00
Katanga	Kampemba Health Center	$3,742.33
	Buafano Health Center	$3,883.00
	Belle Vue Health Reference Center	$4,156.33
	Katanga Health Center	$4,032.00
	Ndakata Health Center	$4,830.33
	Kanina Health Center	$3,649.33
	Kamina General Reference Hospital	$5,986.67
	Quartier 52 Health Center	$4,137.67
	Katuba II Health Center	$4,127.67
	Bukama General Reference Hospital	$6,331.67
	SNCC Health Center	$3,751.67
	Makala Health Center	$4,333.67
	Bukama Health Zone	$1,240.00
	Dilala Health Zone	$1,240.00
	Kamina Health Zone	$1,240.00
	Kampemba Health Zone	$3,750.00
	Kapolowe Health Zone	$3,750.00
	Kenya Health Zone	$3,750.00
	Kikula Health Zone	$3,750.00
	Lubumbashi Health Zone	$3,750.00
	Manika Health Zone	$3,750.00

Region	Recipient	FY2013 funding
	Panda Health Zone	$3,750.00
	Sakania Health Zone	$3,750.00
	Ruashi Health Zone	$3,750.00
Orientale	Ngezi Hospital Center	$3,585.00
	Lembabo Health Center	$2,893.00
	Simbiliabo Health Center	$2,911.00
	De la Paix Health Center	$4,496.00
	Bunia Health Zone	$875.00
	Mangobo Health Zone	$2,500.00
	Tshopo Health Zone	$3,750.00
	Makiso Kisangani Health Zone	$3,750.00
	Kabondo Health Zone	$3,750.00
Bas-Congo	Boma Health Zone	$3,750.00
	Lukula Health Zone	$3,750.00
	Matadi Health Zone	$3,750.00
	Moanda Health Zone	$3,750.00
	Nzanza Health Zone	$3,750.00
	Seke Banza Health Zone	$3,750.00
	Total	**$189,280.08**

Procurement

When ProVIC joined the Supply Chain Management System (SCMS), SCMS took over procurement of pharmaceuticals and laboratory inputs through its procurement and supply system. Through SCMS, ProVIC submitted three orders in 2012, two "PMTCT orders" and one global order of supplies/commodities for activities outside of PMTCT, such as HTC (for community-based and mobile counseling and testing).

There continued to be challenges to smooth procurement, including:

- Theft of 650 Determine® HIV test kits. ProVIC was able to resolve this with the support of SCMS and PNTS/*Centre National de Transfusion Sanguine* (CNTS).
- Delay in delivery of the products ordered by SCMS due to the long customs clearance process.

ProVIC also used local vendors, such as:

- ASF/PSI via USAID for family planning commodities.
- MLT Labotype for DBS kits and biomedical waste management supplies in supported sites.
- MASS TRADING for sensitization materials: notebooks, caps, condom demonstration models, bags, pens, and t-shirts.
- CNTS and Management Sciences for Health/IHP for Determine® HIV test kits.

Table 15 below provides a summary of pharmaceuticals and commodities procured through local vendors.

Table 15. Summary of local vendors to the ProVIC project in FY2013.

Items	Suppliers	Value $
Cool boxes	ARAUPHAR	$440.00
Biomedical waste management	MLT Labotype	$21,370.00
Sensitization kits	MASS TRADING	$28,620.00
DBS collection kits	MLT Labotype	$480.00
DBS collection kits	MLT Labotype	$480.00
	Total	**$51,390**

Environmental monitoring and mitigation activities

Throughout Year 4, ProVIC continued to provide quality assurance and necessary materials, equipment, and assistance to support sound handling of biomedical waste in all supported sites. In FY2013, ProVIC and its partners periodically reviewed adherence to the Environmental Mitigation and Monitoring Plan (EMMP) adherence during integrated supervision visits to each site. These visits were conducted using a checklist to monitor and verify the quality of all activities, including a specific section devoted to EMMP activities in line with national norms and USAID's 2013 health care waste management guidelines. Through these visits, ProVIC ensured that service providers in supported sites followed their plans and respected agreed-upon division of roles and responsibilities.

As a follow-up to these visits, ProVIC provided targeted biomedical waste management training to 53 service providers, 30 in Katanga and 23 in Kisangani. In addition, ProVIC provided biomedical waste management training as one segment of the integrated HIV training focused on PMTCT that was given in five provinces, in line with the Strategic Pivot. As a result, 659 service providers (social workers, doctors, nurses, laboratory technicians, and community workers) were trained in Bas-Congo, Katanga, Province Orientale, and Kinshasa. This training included modules on biosafety, post-exposure accident management, waste incineration and disposal procedures, and maintenance of sterile conditions during testing.

In FY2013, ProVIC also directly invested in EMMP systems in several of its supported sites. Three incinerators were constructed in Bas-Congo, at HGR Boma, CSR Vulumba, and CSR Mbambi. In Sud Kivu, a destruction site for managing biomedical waste was renovated, and a fence built around it to prevent people, specifically neighboring children, from wandering into the site and risking exposure. In Kinshasa and Province Orientale, ProVIC continued to supply adequate quantities of required commodities to ensure proper handling, sorting, collection, transportation, and disposal of biomedical waste. ProVIC provided these supplies and other necessary equipment in Katanga as well. All sites received a minimum package of waste management materials in FY2013, as follows:

ITEM	QUANTITY
Large waste containers	40
Waste containers for sharps	70
Kitchen gloves	48
Plastic tables	48

Rubber boots	48
Rubbing alcohol	100
Bleach (12%)	48
Garbage bags (32 and 60 L)	120
Dustpans	40
Spades	40
Matches	100
Petrol	120
Brooms/Brushes	120
Mops	40
Shovels	40
Wheelbarrows	24
Masks	48